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Exploring the experiences of transitional care from child and adolescent mental health services to adult mental health services: the perspective of professionals, parents and young people

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DECLARATION

This research dossier has not previously been presented in any form to the University or to any other body whether for the purposes of assessment, publication or for any other purpose (unless otherwise indicated). Save for the any express acknowledgements, references and/ or bibliographies cited in the work, I confirm that the intellectual content of the work is the result of my own efforts and of no other person.

Signed: ……..

Date: ……..

ACKNOWLEDGEMENTS

I will make this short and sweet. A huge thank you to every single person who has helped me to along the way, I could not have done this without each and every one of you. So thank you!

WORD COUNT SUMMARY

In order to ensure that I made the amendments identified by the examiners, I have exceeded the word count. The word counts below exclude interviewee quotes, tables, figures and diagrams.

Chapter	Number of words
Chapter 1	1,235
Chapter 2	11,359
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Chapter 5	15,256
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PREFACE

My interest in the topic of transitional care stemmed from my work as an assistant prior to commencing the Counselling Psychology Doctorate Programme. I was particularly influenced by the case of a young person with whom the team had conducted an intensive piece of work. They had successfully re-integrated the client back into the family home following several years of being in care. The young person had just turned 17 years of age when they were accepted as a referral to CAMHS. One aspect of the care plan included supporting the young person as she made the transition into adult mental health. However, several years later the team heard that the young person was using class A drugs, had been working as a prostitute and had been given an anti-social behaviour order. At the point of transition, an agreement had been made between my team and AMHs stating that the young person would contact the services to opt in, which the client did not do. The client was a young person who was known to be vulnerable, hard-to-reach and disaffected. It was not surprising that she had not made contact with adult services.

Although there may have been other factors, it seemed likely that this lack of support from professionals had contributed to the deterioration in her mental health. That deterioration required the involvement of not only the mental health system but also the criminal justice system. This was and still is fundamentally the case that sparked my interest in transitional care. I was left questioning what went wrong. It seemed unrealistic for adult services to expect the young person to opt-in. I wondered why they had discharged the young person and also what efforts the service had made to contact the client. At the time, I felt somewhat frustrated by what I had perceived as a lack of action by AMHS professionals. A part of me also felt that AMHS had not done enough to support the young person. I began to consider how personal values influenced service

protocols and decisions. Perhaps there were differences in the way that I had viewed the young person's needs compared to the perceptions of AMHS. I considered the outcome for the young person and how her circumstances had worsened. Additionally I thought about the cost and practice implications for services and specifically for the counselling psychologists who would now be working with a young person who would likely have even more complex needs, i.e. mental health needs, issues of substance misuse and engagement in criminal behaviour. I had spoken with colleagues who had worked in mental health services longer than I had, and they shared similar stories of difficulties they had experienced whilst supporting the transition of young people between services.

When I started the doctoral programme and was presented with an opportunity to conduct research, this was the topic I chose. At that time there had been no research on the topic. The majority of transition studies were based on physical healthcare needs. This became part of my rationale, and raised questions about whether the transition within mental health services differed from that of physical health transition. If so, I wanted to explore how it differed. The more I read and reflected, the more questions were raised for me.

I designed the study to explore these questions and to provide a platform for stakeholders to talk openly about their experiences. The tentative theory presented is my understanding of their experiences.

ABSTRACT

Transitional care is an important process for professionals to consider, particularly as recent studies have shown how a mental health difficulty in adolescence will persist into adulthood. This indicates that a number of those seen in Child and Adolescent mental health services are likely to make the transition into Adult services. For professionals from both services, barriers can arise when supporting young people across service boundaries and recent studies have stated that the current practice of transitional care in mental health is deemed to be problematic. However at the time of conducting this study, there was a paucity of literature, therefore the aim of the study was to add to the existing knowledge.

The study followed a Social Constructivist grounded theory (Charmaz, 2014) approach to explore the experience of stakeholders of the transition process. Semi-structured interviews were conducted with professionals, young people and parents. There were a total of eight interviews which were transcribed and analysed.

The findings present the core category as *Facing the transition*, with three sub-categories: *Changing status, Manoeuvring the boundaries* and *Reflections on the process*. The tentative theory explains how facing the transition involves stakeholders adjusting to the changing status of the service user. This category triggers the service transition but also describes how societal perceptions about adulthood influence the expectations placed on young people. Manoeuvring the boundaries describes and explains service transition, identifying a range of barriers and strategies to overcome these. One of the most significant barriers was identified as cultural differences between the two services. The third category describes how stakeholders make sense of their experiences, and how these are managed within the therapeutic relationship.

CHAPTER ONE: INTRODUCTION

1.1 Why study transitional care in mental health services?

The National Service Framework (NSF, the government document setting the standards for service providers) has emphasised the need for a smooth and effective transition for service users, both within and between services (DoH, 2004). In 2006, 'Transition: getting it right for young people' (DoH, 2006) was published; the document provided guidelines for transitional care, but explicitly stated that it was not aimed at the Child and Adolescent Mental Health Services. The document defined transitional care as a:

> '…multifaceted active process that attends to the medical, psychosocial and educational/ vocational needs of adolescents and young adults with chronic physical and medical conditions as they move from child-centred care to adult oriented health care systems' (DoH, 2006, p14).

From the definition it is clear that the document is aimed at the transition within physical health services, and the transition of mental health service users is overlooked. Yet globally, in practice, there have been, and still are, difficulties with the transition from Child and Adolescent Mental Health Services to Adult Mental Health Services (hereafter referred to as CAMHS and AMHS respectively). However, studies conducted around transition have highlighted the challenges with transitional care within mental health services, as discussed in the next section.

In a study in the USA, Pottick et al. (2008) explored service utilisation and admission rates based on statistical data collated by the United States Government. They found a reduction in the use of mental health services by young people aged 16-25, following their transition from child to adult services (Pottick et al., 2008). In Australia, it was reported that the unclear referral pathway and the cultural differences between the two services meant that many CAMHS referrals were not accepted by AMHS (Cosgrave et al., 2008, as cited in Singh, 2009, p. 387). This raises the question: What happens to

those service users with on-going mental health needs once they leave CAMHS and do not go on to utilise AMHS. Several UK research studies have reported that the transition of young people from CAMHS and AMHS is problematic, resulting in the unmet needs of young people making the transition (Lamb et al., 2008; Swift et al., 2013; Marcer et al., 2008; Winston, et al., 2011; Young et al., 2011; Singh, 2009; Singh et al., 2008, 2009, 2010). Furthermore Singh et al. (2009, 2010, 2013, 2014) found that the differences in culture, policy, and procedure between the two services may act as a barrier to the continuity of care and effective planning of the transition.

It was not until 2008 that the Government within the UK published specific guidelines for mental health service transition. “Transition: moving on well” (DOH 2008) is an extension of the DOH 2006 paper; however, both the 2006 and 2008 papers are based on a large body of literature that focuses chiefly on the transitional issues within medical and physical health services, and not in mental health services. This author argues that little attention has been paid to this topic from a research perspective; there is a need to examine whether the issues and needs raised in the studies of transitional care within physical health are similar to those raised in mental health services. Without more research evidence, it is difficult to evaluate the relevance and applicability of Government guidelines about physical health to mental health services. Even more important, the Government policy papers offer little guidance about how best to integrate mental and physical health interventions to support the holistic and seamless transition envisioned. A successful transition requires taking into account the medical, psychosocial and educational/ vocational needs of the individual. Based on Government guidance (DoH, 2008), the transition requires a multi-disciplinary approach. Therefore the whole team, including psychologists, might be reasonably expected to share responsibility and accountability for planning and delivering quality transitional support. This group of professionals includes Counselling Psychologists,

who are employed within the mental health system and work with the client group that undergoes the transition.

In comparison to the paucity of research into the transitional care of mental health service users, there is an abundance of literature investigating the transition for service users with physical health care needs (Baines, 2009; Tuchman, Slap, & Britto, 2008; Knapp, Perkins, Beechams, Dhanasiri, & Rustin, 2007; Kirk, 2008; Allen & Gregory, 2008; Sawyer, Blair, & Bowes, 1997). Such studies have provided a crucial evidence base to physical health services with regard to barriers in the transition process, and have been influential in generating change.

Although there may be some amount of overlap, it is debatable whether the Government transition guidelines of 2008 are relevant to the transition process within the mental health services, since there are two different client groups involved, who have differing needs. For example, the needs of adolescent arthritic patients may include the use of specialised equipment, medication and pain management, depending on the level of care required; whereas adolescents with a diagnosis of depression or ADHD may require skill-based training, medication, or psychological interventions. In each case, the context is specific to the individual, and this potentially results in a very different experience for the two client groups, thus prompting a question about their comparability. Moreover, the needs of clients with both physical and mental health care needs may not adequately be met within either service if they operate as distinct entities. Current policy drivers towards integration, personalised care and personal budgets (DoH, 2011) suggests that transitional systems and processes may need rethinking if they are to be fit for future purpose.

1.2 Gaps in the knowledge

It is unclear from the literature exactly why there is little focus on the transition between mental health services. However, from the brief review of the literature it seems that current practice in mental health service transitions is not adequately meeting the needs of young people (Singh et al., 2008). Because of the paucity of literature on this topic, there is a need for researchers to acquire a better understanding of these gaps in current practice. In order to improve transition protocols there is also a need to understand barriers that are potentially unique to mental health transition. At present the scale of the problem is unknown so there is a need to establish the extent of the problem. One way of ascertaining this information would be by collating prevalence data about the number of young people referred to AMHS and the number accepted or not accepted. Finally, the increased emphasis on both quality enhancement and personalised care suggests it is also important to understand how the transition process is experienced by all service users.

1.3 Structure of the report

This research report is divided into six chapters, with each chapter being further divided into sub-sections. The present chapter introduces the topic, by providing an overview of the context of the study, as well as current knowledge in the field that is relevant to this study. The second chapter presents the literature review along with the rationale and aims of the study. Chapters three and four detail the methodology and method. These two chapters present the underlying philosophy of the study, an overview of grounded theory, the research procedures, and finally a description of its application in this study. The fifth chapter presents the findings and discussion together and the final sixth chapter presents an overview of the discussion points, the limitations of the study,

ending with the concluding remarks of the author.

CHAPTER TWO: LITERATURE REVIEW

2.1 Overview

This chapter presents the current literature on transitional care within mental health services. The section provides details about the search strategy. The section also sets the scene, by giving details of the background and context and then ends with the review of the literature on transition between CAMHs and AMHs.

It must be noted that GT theorists have debated the role of extant literature, and differ in their views on when to conduct the literature review. Some argue that one should only engage with the literature once they have developed their major categories (McGhee et al., 2007). The rationale for delaying the search of the literature is primarily based on the need to ensure the data is not contaminated by extant theory/ literature (Glaser & Strauss, 1967). Doing so is seen to enhance reflexivity and induction.

However, it is not uncommon in GT studies to conduct a preliminary search. In contrast to Glaser and Strauss, more recently others such as Schreiber (2001), Hussein et al., (2014) and Bryant and Charmaz, (2007) have discussed the significance of the literature review, as some believe that it enhances theoretical sensitivity. Theoretical sensitivity refers to the researcher's ability to hone in on the subtleties and nuances in the data. Schreiber (2001) El Hussein et al., (2014) suggested that reviewing the literature early can 'guard against potential biases that could be a threat to the rigour of the study' (Hussein et al, 2014, p. 6). According to Strauss and Corbin (2007) it can also provide a secondary source of data that stimulates questions, and directs theoretical sampling, (Strauss & Corbin, 2007). The author agreed with the latter argument and hence a decision was made to conduct a preliminary review of the literature. Furthermore, as the

study was conducted as part of the doctoral programme, a requirement of the course is that the study is an original piece, in order to ensure the author met this requirement; there was a need to review the literature.

2.2 Introduction

Recent literature published on the transition of care from CAMHS to AMHS has highlighted that current practices do not meet the needs of young people (Singh et al., 2014; Petch, 2009). The transition of care runs parallel to the developmental transition, of moving from adolescence into adulthood. Research (Patel et al., 2007; Petch, 2009) has highlighted that adolescents can be vulnerable to mental health difficulties, where the difficulties experienced in adolescence can persist into their adulthood. Therefore, policy and research now focus on the importance of an effective and efficient transition process to ensure the continuity of care (Singh et al., 2009).

However, there is a paucity of literature in this area. In the 2009 article, Singh et al. state that little is known about the extent of the problem; the outcomes for young people making the transition, interventions that might improve the process and the experience of service users and carers (Singh et al., 2009). This study adds to existing knowledge by addressing some of these gaps in knowledge.

This review draws from peer reviewed papers, UK policy and guidance documents, national and international reports, epidemiological studies about prevalence rates, and also theories about adolescence and adolescent mental health.

2.2.1 Search Strategy

A scoping review method was adopted; the benefit of using a scoping review is that it allowed the researcher to include a range of literature, both published and grey literature (Levac et al., 2010). It is a methodical way of organising and describing a body of

literature as well as highlighting the gaps. Arksey and O'Malley (2005, cited in Levac et al., 2010; p. 2) state that the "aim is to map rapidly the key concepts underpinning a research area and the main sources and types of evidence".

The overall aim of the literature review was to develop an understanding of the main themes or concept, in order to increase the understanding of the phenomena, from which a *conceptual framework* was developed. This formed the basis of the inclusion and exclusion criteria of the studies that were reviewed (Gough et al., 2012). The framework was provisional and as knowledge increased, it was modified or refined and then re-applied (Gough et al., 2012). Criteria emerged from the literature reviewed, and so the review process was deemed to be inductive, and was thus applied iteratively (Gough et al., 2012). Through this process, the researcher was able to map out and configure the evidence that elucidated the main concepts, and ultimately provided a broad review of the phenomenon under study. Adopting this approach increased the researcher's confidence that relevant studies had been elicited to add a suitable breadth of understanding of the topic in hand.

Studies were collected from the following databases and search engines: Swetwise, Ingenta, Ovid, CINHAL plus, Wiley Interscience, Emerald Insight, Taylor and Francis health sciences, Blackwell Publishing ltd, Wolters Kluwer, Wiley & sons, The Medicine publishing company, BioMed Central, EBSCO, Elselvier, PsychInfo, Google Scholar, Google, and PubMed. Other sources included websites for the NHS, Department of Health, Social Care, Young Minds, Office of National Statistics and National Institute for Health and Care Excellence.

2.2.2 Iterative stages of literature search

In the initial stages, broad statements were used, for example; *transitional care between child and adult services; transition between CAMHS and AMHS,* and no date criteria

were applied at this stage. This led to several peer reviewed journal articles, the majority of which focused on the aspect of physical health. The search criteria were then further refined to address certain broad questions and statements, such as, *what is the current view on mental health transition from child to adult services*, *transition from CAMHs to AMHs, transitional care in mental health services*. This led to several sources of information that highlighted the current debates and issues on transition of care, including primary research as well as grey literature. Papers were selected based on their relevance to the topic. It became apparent that the TRACK study (Singh, 2009; Singh et al., 2009; Singh et al., 2010; Hovish et al., 2012; McLaren et al., 2013; Paul et al., 2013); was repeatedly mentioned in the literature, and appeared to be one of the seminal studies. The study was a multi-site, mixed method study with four aims: to identify current policy and procedures in place, to identify the process of transition (i.e. transition protocol), to identify the barriers and facilitators of transition, and lastly, to explore the experiences of service users, families and mental health professionals. In short, the findings stated that there were a number of variations in the policies and procedures across the trusts that were involved in the study (Singh et al., 2008). Organisational differences were found to be one of the main barriers to transition, and they resulted in many young people not entering AMHs (Singh et al., 2010; McLaren et al., 2013; Paul et al., 2013). Furthermore, although mental health professionals, service users, and families held negative views about their experience of the transition process, most young people reported significant improvements in their mental condition post-transition (Hovish et al., 2012). Lastly, the TRACK study highlighted the lack of research in this area, and made recommendations for further exploration.

The next stage of the literature review used snowball searches (Greenhalgh & Peacock, 2005) this involved conducting further searches, based on the reference list from the TRACK study. The last stage was performed concurrently, where keywords and terms

(see Appendix 1) from the reference list were used systematically to search for relevant studies. This process was designed to expand knowledge, give information about mechanisms of action, and to identify studies about related phenomena. For example, upon reading the 2013 journal article by McLaren et al. (2013), it became apparent that the TRACK study had published several papers, and therefore, the reference list was searched in order to identify all the publications associated with the study. With each paper associated with the TRACK study, the reference list was checked to search for more articles. Furthermore, when looking at the grey literature, any peer reviewed articles named in the document were searched for, and subsequently used in the literature review.

The search yielded little research prior to 2008, and the majority of studies appeared to have been conducted following the publication of the seminal TRACK study. What did emerge from this process was a significant amount of grey literature that reiterated the findings of the TRACK study, but at the same time focussed on more distal factors that were associated with transition. For example, epidemiological studies looked at the prevalence of mental health difficulties amongst the adolescent population, as well as the onset and duration of mental health issues. Other studies looked at the developmental stage of adolescence and the risk factors that make this group of people vulnerable to mental health difficulties. Emphasis was given to the unmet needs of adolescents with mental health difficulties due to poor transition, and the impact this has on the individual, their social networks (i.e. family and carers), and the community, as well as on an organisational and national scale. The final studies reviewed were papers discussing increasing knowledge regarding the onset and longevity of mental health diagnoses.

A common theme amongst all data selected for review was the lack of research in this area. The paucity of literature supported the use of a qualitative methodology because

the inductive approach is deemed useful to illuminate phenomena that are not well understood (Strauss & Corbin, 1998).

2.3 Background and Context

In an attempt to understand the extent of the problem, a brief look at the prevalence of mental health issues will be presented in this section. In addition, there will also be an overview of the concept of adolescence, with particular focus placed on the vulnerability of this age group to mental health difficulties.

2.3.1 The concept of 'Emerging adulthood'

One of the first formal theories that accounted for biological, psychological and social influences on human development was proposed by Erik Erikson, in his psycho-social model (Erikson, 1950; 1968). He was also one of the first to formally bridge the gap between childhood and adulthood; he identified this as the adolescent stage (Arnett, 2000). This is the age at which the transition occurs. The transition between services will be discussed within the context of theories of human development, and how the developmental needs of young people impact on the experience of transitional care. The section will provide an overview of Erikson's theory but will primarily focus on the work of Jeffrey Arnett (2000) who proposed the term emerging adulthood. The topic of emerging adulthood has been debated among developmental theorists and researchers; some of these debates discuss issues such as, development in the context of the nature-nurture debate, whether development is universal or context-specific, and continuity vs. discontinuity, i.e. whether development follows a smooth progression or is made up of a series of abrupt shifts (Kail & Cavanaugh, 2010). However, these debates were considered to fall outside the remit of the current study and so will not be fully explored here. For further reading, see the works of Arnett (2000, 2001, 2007, 2007a, 2007b),

Arnett & Arnett (2012), Hendry & Kloep, (2010), and Cote & Bynner 2008), Kail and Cavanaugh (2010).

Erikson focused on growth and development. The theory identified 8 stages; at each stage, development occurs by successful resolution of dilemmas (Erikson, 1950; 1968). According to early theorists, adolescence was deemed to start at the beginning of puberty and continued into early adulthood. During adolescence the focus is on identity, and evaluation of ability, interests and childhood experiences (Arnett, 2000). Identity refers to the development of a greater sense of self and individuality within the context of the person's life. Young people of this age explore their identity in various ways (Arnett, 2000). The dilemma at this stage is labelled *identity vs. role diffusion*; here young people are torn between wanting to find themselves and their desire for acceptance and a sense of belonging. Successful resolution is based on the individual finding a balance between the two (Arnett, 2000). However, due to criticisms of his theory, other developmental metatheories have been put forward; these generally fall into one of two theoretical approaches; life span and life course theories of development. Both theoretical positions stem from diverging disciples, life-span is embedded within Psychology, whilst the life-course is embedded within sociology.

The purpose of this section is not to join the debate as to which theoretical approach best accounts for development, but rather to highlight three main factors associated with development at this stage; and how these relate to transitional care. The decision to follow the works of Arnett was based on its relevance to the current study. Additionally, Arnett was the first to propose the period of emerging adulthood. He has also written extensively on the topic. The section will discuss three main considerations about development of the emerging adult. First is that development is a process that occurs over time (emerging adulthood is deemed to span from 18-25) (Arnett, 2007). Secondly, the journey into adulthood typically results in changes in the young person

status, roles and responsibilities. Lastly, the section will discuss how the journey into adulthood influences the dynamics in parent-child relationships.

2.3.2 Development as a process

Since Erikson first proposed his theory, there have been significant social and economic changes, particularly in industrialised societies (Arnett, 2007a). The stages first proposed by Erikson, no longer fit development as it is observed today (Arnett 2000). Researchers such as Arnett (2007) have noted a change in the process of human development, and the dilemma's that Erikson had once conceived as occurring between the ages of 11-18, are now seen to persist into later stages of life; this pattern has also been supported by Cote (2000, 2006). As a result Arnett, (2000) proposed another distinct period of development that overlaps adolescence and early adulthood, and defined this period as *emerging adulthood* (Arnett & Tanner, 2009).

The period between adolescence to emerging adulthood has been considered as a crucial time due to the significant changes that are observed. According to Arnett (2000), development during these stages results in a process of psychological, physiological, and social change. Furthermore, Sneed et al. (2007) proclaim that this age group experience profound role changes across multiple life domains, more so than any other stage of development. In the context of Arnett's work, psychological change refers to identity formation and the development of new mental processes (Arnett 2007). Physiologically, nearing the end of adolescence and the beginning of emerging adulthood, young people would experience physical changes resulting in sexual maturity and full adult size and strength (Erikson 1950; Arnett 2000). Lastly, social change captures the influence of society, social norms and expectations, on development. Socially, as young people near the age of adulthood they are seen to assume more adult roles and responsibilities necessary for adult life (Sneed et al., 2007).

2.3.3 Markers of adulthood

Arnett (2003) noted two main aspects to emerging adulthood, *transition events* (i.e. social markers) and *the subjective experience* (Mayselless & Scharf, 2003; and Nelson, Badger & Wu, 2004). In most cultures, the journey into adulthood is marked by social events also termed transition events, which vary across cultures (Arnett, 2004, 2007). Transition is defined as the "change in roles and statuses that represent a distinct departure from prior roles and statuses" (Hutchison, 2011, p. 14). For the majority of young people in industrialised societies like the UK, the transition into adulthood is marked by events such as moving into independent living, entering the workforce, getting married, and becoming a parent (Sneed et al., 2007). As a consequence of the transitional events, the young person assumes new roles, i.e. employee, parent, spouse etc. However, transitional events and roles are context-specific therefore transitional markers will vary across cultures (Cohen et al., 2003).

In terms of the subjective experience, studies have demonstrated a variation in how the transition is experienced, with some young people feeling optimistic, confident and content (Schulenberg & Zarrett 2006; Galambos et al., 2006), whilst others attribute feelings of anxiety and struggle to make the transition into adulthood (Bynner, 2005; Robin & Wilner, 2001). According to Arnett (2007a) most emerging adults will experience a combination of the two, and often express ambivalent feelings. In simple terms, studies have shown that although young people may have reached chronological age of adulthood, and may have assumed adult roles, they may still express that they do not feel like an adult (Arnett, 2001). This indicates a subjective process in acknowledging their new status of adulthood. In the 2001 study by Arnett, he explored how young people conceived adulthood. He found that although change in role was a marker of adulthood, it was not deemed to be the most significant aspect of the experience. Instead what he found was that young people gave more significance to

qualities of character over a change in role. Arnett (2000), Facio and Mocicci, (2003), and Macek et al. (2003) have identified three important markers that characterise the development into adulthood across cultures; *accepting responsibility for oneself*, *making independent decisions* and *becoming independent* (typically in terms of finances) (Arnett, 2001). This highlights the interaction between the internal psychological world and the external sociological world.

2.3.4 Changes in parent-child relationship

In the journey into adulthood, role transition is considered to play a significant part in the subjective feeling of having reached adulthood (Kins and Beyers, 2010). As young people make their journey, they begin assuming more adult roles and explore their identity (Seiffge-Krenke et al, 2010); they will also develop an increased sense of individuality and autonomy (Arnett 2001). This psychological change results in young people self-regulating, whilst prior to this period young people tend to be parent-regulated (Tanner, 2006; Shoda et al., 1990). In doing so they develop a greater capacity to be self-reliant and demonstrate competence and maturity (Arnett, 2001; Masten et al., 1995). Transitional events such as moving out of the home, entering the work force or going to university are all current trends in the UK and Europe (Buhl, 2007). As a consequence, there is a shift in the parent-child dynamics, as young people make the transition from a dependent relationship to an independent one (Buhl, 2007).

In most cases, parents are the primary attachment figure, and the role of attachment in human development has been well documented in Bowlby's theory (Bowlby, 1949; Cowan & Cowan 2009; George, 2009). The changing role of parents can be seen throughout the life span (Bell & Bell, 2009; Koepke, Denissen, 2012; Beyers & Goosens, 2008; Schwartz, Cote & Arnett, 2005). Brazelton and Cramer, (1990) gave the example of this process in earlier stages of development where parents alter their care-

giving to allow toddlers to act more independently. At the stage of emerging adulthood, as young people begin to redefine themselves they also need to redefine and negotiate their relationships with their parents (Kins, Soenens & Beyers, 2011, Kroger, 1985; Meeus et al., 2005). As, in order for the young person to experience a sense of autonomy, it means they must separate from parents. According to Cooper (2007) this is "both a physical act and a psychological process of detachment" (Cooper, 2007, p349).

This process has been defined as the separation-individuation process (Blos, 1967). Individuation is defined as "the relinquishing of infantile self-conceptions and the establishment of a sense of self that is distinct and individuated from parental object representation" (Kins, Soenens & Beyers 2011, p.647). Nearing the end of this process, the dynamics have shifted from a parent-child relationship to an adult-adult relationship, where young people and parents are considered to be of equal status (Aquilino, 1997; Kins, Soenens & Beyers, 2011; Cooper, 2007; Seiffge-Krenke et al., 2010; Bell & Bell 2009; Buhl, 2007; Scharf et al., 2004; Kins & Beyers, 2010). During this period, each individual exercises their freedom of choice that is often based on their own beliefs and values (Kins & Beyers, 2010). This requires that parents recognise, validate and respect the increased autonomy of the young person whilst at the same time both parties must maintain a sense of connectedness (Kins & Beyers 2010; Gray & Steinberg, 1999).

However, the process of separation-individuation can be an anxiety provoking experience for both parent and young person (Cooper, 2007) and can be perceived as a threat (Cassidy, 1994). As stated by Erikson (1968) there exists a conflict in that, as much as young people desire a differentiated self, they also wish to be nurtured and cared for (Erikson, 1968). In order to support this process, there is a need for parents to promote a family system that has clear boundaries, where young people are encouraged to think for themselves, as well as accept individual differences (Bell & Bell, 2009; Jablonski & Martino, 2013). However, research has identified that in some cases, the

level of closeness between parent-child decreases whilst negative interactions increase (Seiffge-Krenke et al., 2010; Collins et al., 1997). For young people, there is a worry that expressions of their individuality will incite negative reactions from parents (Cooper, 2007); whereas parents who have unresolved issues from their own life history, will struggle to see the young person as separate and individual (Cooper, 2007). In order to successfully resolve this conflict, there must be an acceptance and recognition of 'separateness within the context of an on-going connectedness with parents' (Kins, Soenens & Beyers, 2011). This conflict has been shown to be more pronounced in situations where the young person co-resides with the parent (Flanaghan, Schlenberg & Fuligini 1993). Societal trends have changed within industrialised societies such as the UK, and more and more young people continue to reside at home, as opposed to moving out (Chisholm 1995; Galland 1995; Clark 2007). Another societal change that accounts for the prolonged transition into adulthood has been attributed to the fact that more young people are going away to university (Arnett 2001). In both cases, young people experience difficulties in the process of separation-individuation, particularly due to the fact that they remain in either a dependent or semi-dependent relationship. This can hinder their ability and/ or opportunity to achieve adulthood.

2.3.5 Mental health, development and the problem with transitional care

The period of emerging adulthood is a time of significant change in multiple domains of the young person's life, and the rate of development varies between domains as well as between individuals (Cohen et al., 2003). For most young people there is an observed incremental change that occurs approximately, between the ages of 18-25 (Arnett, 2007), this demonstrates that development is a process that occurs over a period of time. The transition between services usually occurs between the ages of 16-18, which is the start of this crucial stage of development. How this process is experienced by all will

depend on how well the young person and parents can adjust to the changing status, roles and responsibilities. Arnett identified that although this time can be full of uncertainty and anxiety, these feelings tend to subside, and most report improvements in well-being (Arnett 2001). However, for those with mental health difficulties making the transition between services, this is not always the case (McLeod & Brownlie, 2014; Patel et al., 2007). Often young people with mental health difficulties are one of the groups who are most vulnerable and can struggle with the transition into adulthood (Osgood, Foster, Flanaghan & Ruth, 2005).

Young people making the transition between services have been identified as having impaired functioning, which impacts quality of life and hence the need for continued support from services (Tanner, 2014). Depending on the mental health diagnosis the young person can experience impairment in one or more of the following: they can lack the coping skills or resources to manage change, they may have difficulty with emotional and impulse regulation, for those who experience increased isolation or social withdrawal they may have limited opportunities to explore their identity, and this group of young people tend to be more dependent on parents or have come from families with difficult dynamics (Tanner, 2014; Patel et al., 2007; Mendlowicz & Stein, 2000; Alonso et al., 2004; Zatzick et al., 1997; Manning, 2000; Grant et al., 2004; Jackson et al., 2002). As young people make the transition between services, they are somewhat catapulted into AMHs and adulthood between the ages of 16-18, yet may not be at the developmental stage where they would be capable or competent enough manage both transitions. Additionally, developmental research has revealed that the transition into adulthood is a period of adjustment, not only for young people, but for parents also. With more and more young people residing with parents for longer, they remain in a dependent or semi-dependent relationship, yet at the point of transition parents are often excluded from being involved, as will be discussed later in this chapter.

Bearing this in mind, the transition into adulthood becomes an even steeper mountain to climb, as young people can lack the social support or have limited internal resources to manage the developmental changes that lay ahead (Tanner, 2014). Hence, considering the literature presented here, it would seem logical for researchers and practitioners to consider the developmental needs of those making the transition. Thus studies are demonstrating that young people who are service users of CAMHs are at a disadvantage in comparison to their peers who do not have mental health difficulties, in terms of their developmental and life opportunities. Therefore how can they be ready for adult services at 16 or 18? It also leaves one questioning whether developmentally they have the capacity to meet the expectations of AMHs practitioners?

2.3.6 Mental health risk factors associated with adolescence

Research has highlighted that adolescence and early adulthood is a time when young people are vulnerable to mental health difficulties (Jones, 2013; Pugh & Meier, 2006; Hagell, 2014). Today's social climate, with high unemployment rates for young adults, financial challenges, and the increments in the cost of living, makes the journey into adulthood a challenging task, as young adults are not always able to meet the demands or expectations of society; i.e. becoming financially independent (Arnett, 2007).

For some adolescents, particularly those who are deemed to be at high risk, the impact of mental health difficulties can persist into adulthood. Other studies have identified that having a mental health disorder in one's adolescence is a strong predictor of experiencing mental health difficulties in adulthood (Copeland et al., 2013; Visser et al., 2000; Keiling et al., 2011; Green, McGinnis & Meltzer, 2005). For example, an eating disorder has an onset between the ages of 12 – 14, and it will persist for an average of 6 years (Treasure, Schmidt & Hugo, 2000).

Today, approximately 75% of the mental health issues noted in adulthood have their onset in adolescence. This indicates that adolescence could potentially be a crucial time for working with mental health difficulties; and if there is an intervention provided at this stage that targets the needs of this client group, it may be possible to reduce long term psychological distress, by catering to their specific needs. An example of this is the Initiative to Reduce the Impact of Schizophrenia (IRIS project) (Bertolote & McGorry, 2005; Edwards, Harris & Bapat, 2005). Studies looked at the specific onset, duration and needs of those who experience the first episode of psychosis, and emphasised the need for an early intervention service. This is not to say that there is a need for a new service within generic CAMHS, rather, the current service requires improvements.

Therefore, it can be argued that preventative support that is provided early, particularly in adolescence, when studies suggest individuals are at their most vulnerable, can lead to greater personal, social and economic benefits than support provided at any other time in these individuals' lifespan (DoH, 2011). This includes the need for a smooth and effective transition between mental health services. Therefore, there is a need to *'get it right',* as stated by the DoH (DoH, 2006), in the document titled *'get it right'* there is emphasis placed on having a holistic, person centred approach to care, to ensure good communication and joint working between services. This is also supported by other researchers (Birchwood & Singh, 2013; Winston et al., 2011; McConachie et al., 2011; Petch, 2009). According to a survey conducted by Singh et al. (2008), only around 23% of the mental health services in Greater London had specific arrangements for the CAMHS to AMHS transition (Singh et al., 2008). Singh also highlighted that amongst the 23% there was no consistency with regard to the protocol, and this varied between services.

2.3.7 Prevalence of mental health difficulties amongst children and adolescence

One of the first large-scale studies that inspected the prevalence of mental health disorders amongst children and adolescents in the UK was conducted by Meltzer et al. (1999, 2004), in collaboration with the Office of National Statistics (ONS) on behalf of the Department of Health (DoH). Unlike other similar epidemiological studies, the Meltzer study explored this prevalence via questionnaires that were based on certain criteria derived from both the ICD 10 (International Classification of Disorders, tenth revision), and the DSM IV (Diagnostic Statistical manual, fourth revision). However, the study did not focus on mental health service utilisation as a means to gather statistical details, which had been raised as a criticism of the previous studies. Meltzer et al. (1999; 2004) argued that this resulted in misleading figures, because not all young people with mental health difficulties were treated in the primary care settings, e.g. GP surgeries, and were not seen by specialists. The study involved 10,438 young people who were recruited via the Child Benefits centre (who held information about those in receipt of state benefits for their childcare costs). The researcher involved in the Meltzer study gathered statistical data about the prevalence rates of conduct disorder, emotional disorders, and hyperkinetic disorders that was based on the criteria in the ICD 10 and DSM IV. From the study, it was identified that one in ten 5-16 year olds had a mental health difficulty (Meltzer, 1999; 2004). The 1999 study was repeated in 2004 where it was seen that statistically, the prevalence rates in the UK had remained relatively stable (Meltzer et al., 1999, 2004). More recently, the National CAMHS support service published a report from a survey where they collated data of referral rates to the CAMHS in 2003, and again in 2008/9, and they identified that the referral rates within that time had increased by 40%, and subsequently suggested that this was evidence of an increased demand for CAMHS services (CAMHS support service, 2011). Some

explanations for the increments that were seen could be explained by factors such as a greater awareness about mental health difficulties. Another explanation is the increase in risk factors, as a result of the recent financial crisis, which led to high rates of unemployment-related student debt, and according to Hagell (2014), led to a collapse of the youth labour market (Hagell, 2014).

Other significant statistical data in relation to transition services focus on the epidemiology of mental health difficulties. It is now known that a large proportion of mental health difficulties will first present during adolescence; for example, Treasure, Schmidt and Hugo (2000) found that eating disorders frequently first develop between the ages of 12-14, and have a pre-diagnosis duration of approximately 6 years. Similarly, Kessler et al. (2007) conducted a literature review and found that the onset of psychosis predominantly occurred in childhood and adolescence. Kim-Cohen et al. (2003) reported that 80% of adults who experienced anxiety and depression in 2003 had their first episode before the age of 18. Similar findings have been obtained on a global scale. Patel et al. (2007) conducted a meta-analysis of the prevalence of mental health issues on a global scale for the age group of 12-24 years. This was conducted using data held by the World Health Organisation (WHO), and the study documented the age of onset of mental health disorders worldwide. Kessler et al. (2005) concluded that half of all adults who experienced at least one mental health difficulty in their life-time had their first onset around the age of 14.

Other studies have looked at the impact or disease burden of mental health difficulties with the use of disability adjusted life years (DALY), which is the number of years that were lost as a result of ill-health, disability, or early death (Murray & Lopez, 1996). According to the statistics, five of the ten leading causes of DALY worldwide are due to mental health difficulties (Patel et al., 2007). The latest figures quoted by the WHO in 2008 stated that in the UK, mental health difficulties accounted for 22.8 % of disability,

much greater than the figures for cancer (15.9 %) and cardiovascular disease (16.2 %) (WHO, 2008, cited in DoH, 2011).

Briggs (2009) presented the limitations of studies reporting prevalence rates and statistical patterns of mental health difficulties. He stated that there are inconsistencies amongst findings, a claim also supported by Patel et al. (2007). Some of these limitations include variations in the criteria used to define mental health difficulties. Some studies use either the DSM or ICD 10, and in other cases both are used, thus making the process of comparison across studies a difficult task (Patel et al., 2007). Additionally, Patel highlights that a majority of these are retrospective studies, and they rely on the feedback of parents, and this approach has been criticised due to issues of recall bias (Briggs, 2009; Patel et al., 2007; De Nicola & Ginè, 2014). However, Briggs concludes that because of the inconsistencies of findings, it is difficult to ascertain the accuracy of such research and suggests reading such literature with caution (Briggs, 2009).

In spite of this, what can be taken from such studies is that there are a significant number of young people who experience mental health difficulties in the UK. Of those that do, there will be a cohort of young people whose mental health difficulties will continue into adulthood. This cohort is most likely to make the transition into adulthood. Research is indicating that there is an increase in referrals seen in CAMHs and potentially leading to an increase in the number of young people likely to need on-going support into adulthood. This highlights the importance of conducting research into transition care to ensure that it adequately meets the demand placed on services.

2.4 Transitional care within Mental Health Services

2.4.1 Defining transition of care

There is no clear-cut definition of the transition of care, but Singh (2008) does provide a working definition, based on the components of the transition process:

> '…a situational event, where young people move from one service to another' (Singh et al., 2008, p.2).

In a later paper (Singh et al., 2010), this definition is further elaborated:

> '…a fluid process that occurs over time, incorporating actions and events, such as preparing young people for transition, joint working, and transitional meetings' (Singh et al., 2010, p.8).

Vostanis (2005) argued that the transition of care occurs concurrently with the developmental transition, where young people move from child status to adult status, and if the service providers view transitional care in terms of logistics and as an administrative task, then there is a chance of ignoring the developmental needs of this client group. On this basis, Singh et al (2008) identify a third component of transitional care, the life stage transition, acknowledging that young people may also need to be supported though status transitions as they move from child to adult status in the eyes of society (Singh et al., 2008).

The transition between services is not a topic unique to the mental health services. There are multiple forms of transition, and even CAMHS has several transitional trajectories (Lamb, 2013). However, difficulties in transition arising from current practices between the CAMHS and AMHS have generated recent political and academic attention (Singh et al, 2008). In order to understand the difficulties in transition, it is necessary to understand the contextual factors associated with the transition process. The following section will provide a brief overview of these factors, focussing specifically on the differences between the two services.

2.4.2 CAMHS- AMHS Divide

CAMHS describes the overarching NHS provision as a body whose primary role is to "address and alleviate the mental health needs of children and young people" (Royal College of Psychiatrists, 2013, p. 12). Interventions can include working with the individual, in groups, or with the whole family (Royal College of Psychiatrists, 2013). Richardson, Partridge and Barrett (2010) further defined CAMH services characterised by a multi-disciplinary approach, where they are child and family-orientated, and it considers the social, educational, emotional, as well as the medical needs of service users.

In addition to offering treatment, CAMHS practitioners also have a duty to provide support and advice to families and other professionals. The age range of CAMHS service users is usually between the ages of 0-18 (NICE, 2011) and the transition to adult services occurs at the age of 16 years (Singh et al., 2010). AMHS is usually a community based and multi-disciplinary team that provide specialist assessment and treatment to adults with mental health difficulties. AMHS have a much wider age range, typically between the ages of 16-65. Adult services follow the Care Programme Approach (CPA), which is a model of service delivery that is used across the UK. The CPA organises care, whereby each person once accepted will have their needs assessed, and be allocated a named mental health professional, who will then co-ordinate care (also referred to as care co-ordinator), and together they will agree upon a care plan that supports the service user's needs, which is then reviewed regularly (DH, 2008). The CPA can include vocational, social and specific mental health treatment. Similar to CAMHs, AMHS also provide medical and psycho-social treatment of mental health difficulties, and both services are governed by the NICE guidelines (NICE, 2011).

CAMHS is divided into three groups; *universal services/ tier one* (GP's, health visitors, school nurses), *targeted services/ tier two* (looked after services, school counsellors)

and *specialists services/ tier three and four* (multi-disciplinary teams, in-patients) (Lamb, 2013; Richardson et al., 2010). Interventions for young people experiencing mental health difficulties can occur at any level, and young people can move up or down the system. A service user can reach the age to trigger transition while being treated within any of the four tiers, since the allocation is determined by clinical severity. In practice, Tier Three teams see the most complex and enduring mental health difficulties, and these are also the young people who are most likely to make the transition to adult mental health. AMHS has a similar configuration, with a majority of adults treated within primary care settings; while secondary care focuses on the most severe and enduring mental health difficulties. For the research study presented here, Tier Three was the selected location, because they work with the most severe end of child and adolescent mental health difficulties. Also, when looked at pragmatically, this is the Tier where the greatest number of transitions between CAMHS and AMHS occur (Lamb, 2013; Singh et al., 2010). Therefore, the terms CAMHS in this study refers to the specialist CAMHS teams and AMHS refers to secondary care teams.

The two services vary in terms of their remit, which results in differing thresholds and criteria. CAMHS has a lower threshold for entry into their services, because they are not only catering for those with mental health diagnoses but also those who are exhibiting early signs of a diagnosis but do not reach the criteria. These include young people who may have high levels of impairment in different aspects of their life. For example, CAMHS would accept a referral for a young person who has difficulties with relationships, emotional regulation and may be self-harming as a coping strategy because this pattern may suggest the development of a diagnosable mental health condition. In addition, CAMHS will also work with developmental disorders, such as Autism and ADHD. AMHS, on the other hand, has a much higher diagnostic threshold, and the majority of adults with mental health difficulties will successfully be

managed within primary care settings (Lamb, 2013), leaving AMHS to work with service users experiencing severe and enduring mental health difficulties. These variations can lead to difficulties at the point of transition, as the definition of a severe and enduring mental health difficulty in CAMHS may not necessarily reach the higher threshold of AMHS (Singh et al., 2013; Lamb, 2013; Birchwood & Singh 2013; Richardson et al., 2010).

The difference in remit, threshold, and criteria generates (or promotes) differences in service configuration, working practices, professional training, service cultures, and the policies and procedures. In terms of making certain decisions about treatment, AMHS assume that all persons have the capacity to make decisions, and efforts must be made to ensure that all possible steps have been taken to help the individual make those decisions. Only if all the steps taken have been unsuccessful, is it then assumed that the service user does not have the capacity to make the decisions, and then the mental health professionals are able to apply the Mental Health Act (2005).

If a person is deemed to have the capacity, then decisions will be made jointly between the care co-ordinator and the service user, where the mental health professionals are under no obligation to involve parents, unless the service user has requested for their involvement, or if it is in the best interest of the service user. The power to make decisions remains amongst the mental health professional and the service user. The question of capacity and who is responsible for the decision making is slightly less clear in CAMHS (Paul, 2004), and is very much dependent on the developmental stage of the service user. Due to the questions of capacity, CAMHS would usually seek consent from a person who holds parental responsibility. Therefore, the responsibility and decision-making is shared amongst the mental health professional, the young person, and the parent, or the person who holds parental responsibility (Paul, 2004). A person who holds parental responsibility could be a parent, carer, or in the case of Looked after

children, it could be a professional, and although the author acknowledges there are differing dynamics with each of these roles, for ease of understanding, the term parent will be used in the report to refer to anyone who has parental responsibility.

2.4.3 Ethical challenges during transition

A further difference between the two services is the involvement of parents during the treatment, which can create ethical challenges for the mental health professional throughout the transition process. The involvement of parents in treatment is based on the issues about *decision-making*, *capacity*, *consent* and *best interest*. The following sections will briefly discuss these issues, for a more in-depth discussion see Paul (2004). When considering consent to treatment, there is variation in the legal framework and guidance documents dependent on the developmental stage of the individual. In short, the law varies for those under 16, between 16-17, and those who are 18 and above, and the reason for this is based on the capacity to make decisions.

2.4.4 Capacity and consent

All the mental health professionals in the NHS need to gain consent for treatment before it can be administered, and in order to do so, it is vital to establish whether the individual is legally competent to make decisions about their treatment, i.e., has the mental capacity or not (Mental Capacity Act, 2005). Mental capacity is assessed on a decision by decision basis according to the following principles, as detailed in the Mental Capacity Act (2005):

- The level of understanding of the individual;
- The ability to retain information;
- Ability to consider all information as well as any possible implications;
- Be able to communicate their decisions.

If a service user is not able to demonstrate one or more of the above tasks, then they are deemed to be lacking in mental capacity, at which point the mental health professionals may apply the Mental Capacity Act (2005) or the Mental Health Act (2007), as required with careful consideration. The law clearly states that one is not to make assumptions about capacity based on age, appearance, mental health diagnosis, disability, or other form of medical condition (Mental Capacity Act, 2005). All people above the age of 16 are presumed to have capacity unless it is shown that they have not. This includes some young people under 16, in some circumstances, based on Gillick competence (Knott, 2011), who have demonstrated "sufficient understanding and maturity to understand what is being proposed" (Knott, 2011, p. 2).

As the aforementioned transition usually occurs between the ages of 16-18, by law, these young people are deemed to have the competence or capacity to make decisions about their treatment unless assessment has shown that they have not. However, the Department of Health (2001) emphasises that it is good practice to encourage young people to involve their families or parents in the decision-making process, particularly because any individual who holds parental responsibility for a child under the age of 18 has a legal right to be involved, and give consent, with regards to their child's treatment (Paul, Newns & Creedy., 2006; cited in Winston et al., 2011), unless it is not in their best interest and/or could lead to their potential harm. For those who do not have the capacity to make their own decisions, it will be made by a person who holds parental responsibility (this could be a parent, carer, or in the case of those in the Looked after care system, a professional). The issue arises when the parent gives consent, but the 16-17 year old service user does not agree. In such circumstances, the service user cannot refuse treatment. However, if the service user consents to treatment, the person with parental responsibility is not able to overrule it. So, what this essentially means is that although the 16-17 year olds may have the capacity, they do not necessarily have the

same rights as adults. It is only when they reach their 18th birthday that no one is able to give consent on their behalf, unless deemed to be lacking capacity, in which case the Mental Health Act (1983) applies.

What this means in practice is that the dynamics of decision-making vary in CAMHS and AMHS. Decision making in CAMHS involves the mental health professional, parent and service user, where although the young person may have the capacity, they may not necessarily be the primary decision-maker in the process. Young people have more of a participatory role (Paul, 2004). This changes once the young person moves into adult services, where the young person is then seen as the primary decision-maker, and parents are then somewhat demoted to a participatory role (Lansdown, 2000, cited in Paul, 2004, p. 303).

2.4.5 Parental involvement

The remit of CAMHs does end with the treatment of the child, but it also extends to the provision of support and guidance to the parents or carers (Royal College of Psychiatrists, 2013). Richardson et al. (2010) emphasised that CAMHS mental health professionals cannot work with the young person in isolation, as there is a need to consider the impact of social factors when assessing and formulating the young person's difficulties. Therefore, there is a need to consider the young person within the context of their social environment, i.e., the family, friendship groups and school. Viewing the young person's difficulties out of the social context can lead to a potentially dangerous situation, whereby the responsibility of the adults in the life of the young person is diminished. Richardson et al. (2010) stated that viewing the child or young person's difficulties in terms of pathology only, can lead to the young person being stigmatised and may cultivate low self-esteem (Richardson et al., 2010).

Moreover, families are the main support network for children and young people, and can provide a stabilising environment. Therefore, by working with the family of the young person, mental health professionals are building on the existing resources available to the young person (Petch, 2009). Additionally, if the young person feels stigmatised, families can also experience a similar stigma, as a result of the young person's mental health difficulties, and they too can face increased isolation with dwindling social support. So, they too may require some support from social services (Shepherd, 2008).

2.4.6 Barriers to transition

The literature search led to forty-four articles specifically focused on the mental health transition worldwide, of those, thirty were literatures reviews. The remaining fourteen of the forty-four were actual studies that directly explored transition within the mental health services, out of which three were international literature, and eleven were UK-based. Of the international studies, Styron et al. (2006) conducted an evaluation of a specially designed youth service in the US, Munson et al. (2001) explored the issues of mistrust, emotions, and insight into the relation to transition in the US, and lastly Dimitropoulos et al. (2012) explored the transition of young people with eating disorders in Canada. The eleven UK-based studies explored the transition of young people with eating disorders (Arcelus et al., 2008), and ADHD (Marcer et al., 2008; Swift et al., 2013; Hall et al., 2013).

The TRACK study conducted by Singh et al. was the only study that explored the process, outcome and experiences of transition from CAMHS to AMHS. According to Singh et al. (2010; 2013), this is the only study of its kind worldwide and has contributed a significant understanding to the current practice of transitional care. However, a major criticism of the TRACK study was the inability to achieve all the

research objectives due to difficulties with recruitment. Styron et al., (2006) used mixed methods, recruiting 60 participants to complete questionnaires and a small number (n=12) of semi-structured interviews. Dimitropoulous et al. (2012) also conducted a grounded theory study exploring experiences of transition. However, none of these studies adequately addressed how quality was evaluated. Swift et al. (2013) and Hall et al. (2013) also had small samples sizes and they focussed on one specific geographical location. Although Leavey et al. (date unknown) are due to replicate the TRACK study in Northern Ireland, they have not yet published any papers from this work. To the best of the author's knowledge, only the TRACK study was found to be generalisable, due to the larger sample sizes in each of the studies, as well as the application of a mixed method and multi-site design that involved 65 CAMHS teams, followed 154 incidences of transition, and conducted a considerable number of interviews with young people, parents, and professionals (n=34). On this basis, although this section aimed to critically evaluate and summarise the findings of all fourteen studies, the TRACK study was a dominating feature of the discussion, because of the breadth and methodological quality of the study. The next section will detail the different factors highlighted as barriers in the literature review.

2.4.7 Organisational and Cultural differences

The review of the literature elicited organisational differences to be one of the main barriers to transition (Marcer et al. 2008; Swift et al., 2013; Hall et al., 2013; Arecelus et al., 2008; Mclaren et al., 2013). Lamb and Murphy (2013) state that there are national, regional and local variations in how the two services are governed, commissioned and managed (and how policy guidance in interpreted) (Lamb, 2013). This can create barriers to communications about transitional care at commissioning level, as well as barriers further at the service level (Marcer et al., 2008). Additionally, McLaren et al.

(2013) identified the influence of cultural differences and defined organisational culture as “that which is shared by members of groups and expressed in patterns of behaviour and is conceptualised as shared beliefs, values, understandings and norms that bind members [. . .]” (McLaren et al., 2013, p. 2). Cultural differences were understood in terms of the values, beliefs and attitudes that were held by mental health professionals in both CAMHS and AMHS. In particular, two main themes emerged from the McLaren et al. (2013) study, which were *service cultures* and *communication/working practices*. Participants viewed CAMHs as person-centred, family-orientated, with a focus on talking therapies and building resilience (McLaren, 2013). On the other hand, AMHS were seen to focus on the individual, crisis management, medication, and AMHS mental health professionals reported feeling under-skilled and lacking in confidence about working with young people (McLaren, et al., 2013). Similar barriers were also reported in three of the other studies (Dimitropoulos et al., 2012; Hall et al., 2013 and Arcelus et al., 2008). An outcome of the cultural differences was indicated by Arcelus et al. (2013), who conducted statistical analyses of a range of self-reported standardised questionnaires, in order to ascertain the outcomes for young people, that those who had previously been seen in CAMHS reported lower self-esteem and more fears about autonomy and taking responsibility, in comparison to those who had not previously had CAMHS input. They accounted for this difference by suggesting that this was evidence that upon leaving CAMHS, young people were not prepared for the organisational difference.

The young people interviewed in the McLaren et al. (2013) study reported experiencing a ‘culture shock’ when entering adult services, and both parents and young people described that AMHS focused more on medication management and crisis intervention, with less emphasis on the emotional problems. Additionally, parents and young people described the cultural differences and philosophies as confusing (Viner, 1999). An

interesting finding of the TRACK study in relation to values, beliefs and attitudes, was that although 131 out of 154 cases were deemed to be appropriate for transition, only 102 were actually referred. Upon querying the participants from CAMHS, it was said that one of the reasons was due to CAMHS mental health professionals presuming that the referral would not be accepted by AMHS. The authors of the study regarded this as a misperception and misunderstanding on the part of CAMHS (Paul et al., 2013).

2.4.8 Working practices and communication

The cultural differences between the two services were deemed to be due to the different remit of the two services, as discussed in earlier sections. This difference in remit led to differences in the threshold, eligibility and the service provision offered. There were several reasons for young people not making the transition. Although the common issue around eligibility and threshold focussed predominantly on one diagnosis, where Singh et al. (2008) reported that of the 154 cases, one third were not transitioned, because of the diagnosis. Where the findings suggested certain diagnoses treated in CAMHS that did not meet the threshold for AMHS, and so AMHS did not have the provisions to cater for their needs, which further resulted in certain diagnoses deemed ineligible (Paul et al., 2013; Richards & Vostanis, 2004; Singh et al., 2010; Marcer et al., 2008; Swift et al., 2008; Hall et al., 2013). This was further elucidated by Hall et al. (2013), who found that 63% of participants (n=30) perceived that the main reason for AMHS not accepting service users with ADHD was because they did not meet the criteria. However, Paul et al. (2013; part of the TRACK study) conducted a case note survey, following the transition of 154 young people over a 12 month period, and found that in addition to ineligibility, the most common reason for young people not making the transition in their study was due to the young person and/or the family refusing the service.

Other diagnoses or mental health difficulties that Singh et al. (2010) identified as difficult to transition included neuro-developmental disorders, mood disorders and emerging personality disorders. According to the parents interviewed in the Richards and Vostanis (2004) study, they felt there was a lack of services for those leaving the 'Looked after' system, homeless young people, those with alcohol and substances misuse (as the current age boundary for this specialist service is 18yrs and older), people with learning disabilities, and those with behavioural difficulties. McGrandle and McMahon (2013) argued that the threshold for AMHS is too high and the eligibility criteria too restrictive, resulting in the unmet needs of young people with specific diagnoses, which ends in poor outcome for young people (Singh, 2009).

The age boundary between the two services was seen to be another common barrier, because it was reported to be too rigid (Singh, 2009), outdated (Richards & Vostanis, 2004) and inconsistent, with the age boundaries of other agencies (like social care) (Richards & Vostanis, 2004). Singh (2009) suggested the need for services to weigh up chronological age with developmental needs of the service user. Singh et al. (2008), upon conducting a content analysis of 13 protocols, from the various sites involved in the study, found inconsistencies in age boundaries, not only between services, but also within services, where different services within the AMHS had difference age boundaries documented in their transition protocols. These support the findings of qualitative studies, where professionals from both CAMHS and AMHS have reported a lack of clarity about the transition process (Hall et al., 2013; Arcelus et al., 2008; Singh et al., 2008).

Communication barriers were listed to be another major contributing factor to the poor transition experience. For the purpose of this review, communication is viewed in two forms, verbal (formal and informal discussions), and non-verbal (i.e. transfer of information). Richards and Vostanis (2004), in their thematic analysis of interviews

with professionals from statutory and non-statutory services, found that the discussions were focussed on debating who was responsible for the client, and also that there were variations in communication, dependent on the individual. Other factors which led to poor communication were time constraints due to high workloads, (Richards & Vostanis, 2004). Singh et al. (2010) found that the information sharing was difficult due to the differing IT databases that were used to record client care, which meant that the two were separate and incompatible, thus creating barriers in sharing information during the transition process (Singh et al., 2010).

However, for some of the sites involved in the TRACK study, this was overcome with the use of the Care Plan Approach document, which was viewed to be a facilitator to the transition process as it provided a standardised way of recording information and alleviated difficulties in communication (Singh et al., 2010). Another facilitating factor to reduce communication difficulties was to hold joint meetings with all stakeholders of the transition process (including the parents, the young people, CAMHS and AMHS professionals) (McLaren, et al., 2013; Paul et al., 2013). The outcome of such barriers led to the poorly planned and ineffective transition which resulted in a poor experience for the service user (Singh et al., 2008; Singh et al., 2010; Paul et al., 2013; McLaren, et al., 2013; Hovish et al., 2012).

Lastly, the literature highlighted the developmental needs of this age group, which added further complexity to transition within mental health services. Richards and Vostanis (2004) highlighted the multi-faceted and multiple transitions that the young people face at the transition age. Richard also pointed out that young people can be viewed as a minority group both in the CAMHS and AMHS, and highlighted that the need of this group had been overlooked (Richards & Vostanis, 2004).

At present, the literature suggests that these needs are not met adequately, and as a result, can lead to poor experiences for young people and families (Singh et al., 2008;

Hovish et al., 2012; Islam, 2011; Swift et al., 2013; Arcelus et al., 2008; McLaren et al., 2013). A common theme amongst the studies focussed on the developmental needs of this age group, highlighting the fact that this was the age at which young people took on more adult roles and responsibilities. For example, Hovis et al. (2012) identified that the participants had either become parents or moved out of the family home. In addition, participants also underwent multiple transitions, for example, those with physical illnesses made transitions from paediatric care to adult health care providers (Hovis et al., 2012). Richards and Vostanis (2004) support the findings of Hovis et al., (2012) where they described multiple transitions in terms of multifaceted needs. Participants in the Richard and Vostanis (2004) study stated they would have liked support with housing and finances.

Therefore, the developmental needs also play an important role during transition, as most of the studies reported that although some young people were willing to embrace their new-found independence, they also expressed ambivalent feelings. Richards and Vostanis (2004) reported that mental health professionals identified themes such as the process of individuation, identity formation, and influence of youth culture arising as part of their work to support the young people through transition.

2.4.9 Changing relationships and support

Singh et al., (2010), spoke about the lower level of parental involvement as another change in the lives of young people, and although young people reported welcoming their new found independence, they also felt overwhelmed and intimidated (McLaren, 2013). Singh et al. (2010) highlighted that due to the multiple changes and parallel transitions that occur at the same time during the service users' adolescence, the transition within the mental health services requires flexibility, in order to balance the service users' chronological age with their developmental needs (Singh et al., 2010).

Finally, the outcome on the lives of young people was a change in relationships. Young people who participated in semi-structured interviews about their experiences of the transition as part of the TRACK study emphasised the value they placed on the therapeutic relationship with their CAMHS worker, and how the transition to AMHS led to feelings of loss, cultural shock and anxiety (McLaren et al., 2013). This was supported by the findings in other qualitative studies, such as those found by Islam et al. (2010), Hovish et al. (2012) and Arcelus et al. (2008). The transition also led to changes in family dynamics, as often the outcome of the transition resulted in lower levels of parental involvement (Singh et al., 2010; Hovis et al., 2012; Islam, 2011; Arcelus et al., 2008; Swift et al., 2013). Several of the studies discussed the important role that parents can play in the lives of young people with mental health conditions. In particular Munson et al. (2001) reported that young people felt family members and parents played a vital role in aiding them to access mental health services. Parents and family members were able to support the young person with making adjustments required, as part of the transition. Additionally, Arcelus et al. (2008) stated that the development of young people can sometimes be disrupted or delayed as a direct result of mental health difficulties, and therefore, they may not have the necessary resources to meet the social and service expectations placed on them. In such instances, the support of parents is vital (Arcelus et al., 2008).

Parental reports from qualitative studies found that the parents often felt a sense of loss, feeling of being left out in the dark, and found this to be a period of adjustment with plenty of anxiety, and some parents felt unprepared for the transition (McLaren et al., 2013; McGrandle & McMahon, 2012; Richardson & Vostanis, 2004; Hovis et al., 2012; Swift et al., 2013). An article that explored parental experiences was conducted by Mohr and Regan-Kubinski (2001); participants included parents who had adolescent and adult offspring with mental health diagnoses. The study found that the parents often

experienced a sense of loss in relation to the loss of the *ideal child*, and the study related this to the experience of grief, and stressed upon the importance of mental health professionals being aware of the impact on families and parents (Mohr & Regan-Vostanis, 2001).

2.5 Conclusion

In summary, the transition between CAMHS and AMHS is a complex and dynamic process. Mental health difficulties experienced in adolescence can persist in adulthood, and it can prove to disadvantage young people in financial, emotional, developmental and social aspects of their lives. What is also particularly challenging for this group is that whilst they are making the transition between services they are also at a point in their life course their lives where they undergo many changes. Therefore, it is imperative that the services providing support to this age group are aware of the complexities involved. The explicit message expressed in both research papers and literature reviews was that the transition between mental health services is an area that is poorly understood in theory (Munson et al., 2001; Stryon et al., 2006; Dimitropoulos et al., 2012; McGrandles et al., 2012; Gillam, 2004), and subsequently, poorly planned, executed and experienced in practice (Singh et al., 2010; Richards & Vostanis, 2004; Paul et al., 2013; Hovish et al., 2012). Therefore, this study aims to add to the current knowledge by exploring the experiences of mental health professionals using a grounded theory approach because it aims to be theory building. At the time of conducting the research, there was little research material to be found, and hence it was deemed appropriate for a qualitative approach to be used to explore ill-understood concepts

2.6 Rationale for the study

This section summarises the findings of the literature review and how these inform the emergent research question. There is a consensus amongst researchers, professionals, and policy makers that the current practice of transitional care within the mental health services is not fully effective, and does not always meet the needs of those making the transition. This increases the likelihood of some young people falling through the gaps between services.

The mental health of the adolescent population has been somewhat overlooked; this may be because they are a minority group among service users within the CAMHS as well as the AMHS, as suggested by Richards and Vostanis (2004). Whatever the reason, it does not take away from the fact that adolescents with mental health difficulties will eventually be the adults of the future, and it is therefore imperative that the service transition sees improvements. Over the last several years there have been more peer reviewed articles exploring the topic, yet the subject is still not fully understood, and professionals may not be aware of the complex nature of the transition between CAMHS and AMHS. Therefore there is a need for more research exploring the transition process, to increase knowledge of the topic. In addition there is a need to emphasise this topic within the realm of research, in order to generate the interest of other researchers. The Government has stated that mental health is the business of all professionals working across agencies, and this includes counselling psychologists, who are among the professionals who provide support to young people during the transition.

At the time when this research project was initiated, very few peer reviewed studies on the CAMHS-to-AMHS transition had been published; therefore it was considered appropriate to apply a grounded theory approach, in order to develop a theory to explain this transition process.

2.7 Aim and research questions

As a result of the literature summarised in the preceding section, it was possible to identify the aims and research. The aim of this study is to explore the transition from CAMHS to AMHS from the perspective of stakeholders, i.e. young people, parents and professionals from both services. The findings will be used to evolve a theoretical framework that describes and explains the transition process. It is expected that this framework will help professionals working in the transitional care of young people to understand more fully the complex nature of the transition process. The research will also identify some of the challenges and enabling factors that could help professional health care workers manage transitions more effectively. In order to achieve these aims the research questions to be addressed were:

1. What are the experiences of services for people involved in young people's mental health?
2. What factors influence their experience?
3. What are the outcomes for young people who move from child services to adult services?

The next chapter will outline the research design and process.

CHAPTER THREE: METHODOLOGY

3.1 Overview

The following section provides details of the ontology, epistemology and methodology of the research. A brief discussion will be presented explaining how Grounded Theory (GT) was developed and the influential factors that have shaped the method over time. Lastly the section includes a discussion showing how the research has been influenced by the Social Constructivist Grounded Theory approach devised by Charmaz (2008, 2011, 2014). Fundamentally, here the author has demonstrated her understanding of the chosen methodology and how it has shaped the study.

3.2 Brief history of the evolution of GT

Grounded theory (GT) is an inductive [1]qualitative method developed by Barney Glaser and Anselm Strauss (1967). Grounded theory has evolved and been modified several times since its conception, resulting in several variations of GT. The variations include the original method developed by Glaser and Strauss (1967), The Straussian approach developed by Strauss and Corbin (1998), the Glaserian approach (which remains true to the original; Glaser 1978, 1992, 1998) and Charmaz's Constructivist approach (2000). The variations arose as a result of broader discussions about the philosophical, epistemological and methodological stances of research methods.

[1] The term inductive describes how research moves from making specific observations to more generalisations or theories. It is also referred to as the 'bottom-up' approach.

At the time GT was developed, these debates reflected tension between quantitative and qualitative methods. The tension stemmed from the differences in the underlying assumptions about how knowledge is acquired (epistemology), how research is conducted (methodology) and what constitutes a 'good quality' piece of research (rigour). Some of the contributors to such debates included Blumer, (1954), Garfinkel (1954), Kuhn, (1967) and Fleck (1979), and more recently Mills et al. (2006) and Age (2011). Ultimately, such debates generated a shift from the logical positivist perspective, with an acceptance that the pursuit of a single central truth in research is unhelpful, as stated by Denzin and Lincoln (2005, cited in Birks & Mills, 2011). Social Constructivism grew in popularity and became more accepted and valued amongst researchers. The following section will give a brief overview of some of the key points of the debates and how they shaped grounded theory.

The quantitative approach is embedded within realist ontology[2] and positivist epistemology[3] which assumes that there is an independent objective reality and a unitary truth (Smith, 2008). According to positivists, the world can be studied through observations, replicating experiments and defining concepts (Popper, 1972). From this, one is able to develop hypotheses, which are universal statements that are either proved or disproved with evidence (Reichenbach, 1938). Within this research paradigm, the researcher is viewed as an objective observer who acquires knowledge through the hypothetical-deductive method and focuses on testing existing theory (Charmaz, 2014). Within the positivist paradigm, the quality of research is judged based upon the concepts of reliability, validity and representativeness (Charmaz, 2014). Due to positivist beliefs being championed during the 1960s, these concepts were also used to

[2] Ontology – refers to the nature of truth and reality
[3] Epistemology – refers to how knowledge is acquired

judge and criticise qualitative methods. The critics called qualitative studies subjective, anecdotal, biased and lacking credibility and validity (Charmaz & Bryant 2013). Qualitative research was criticised on the basis that it was deemed to be unsystematic and lacking in rigour, meaning that replication was not always possible, making it challenging to verify any findings (Charmaz & Bryant, 2013). Moreover, it was argued that the interpretative nature of qualitative research increased the likelihood of researcher bias (Charmaz & Bryant 2013). In short, qualitative research was believed to lack the kind of rigour that was seen in empirical research (Smith, 2008), relegating qualitative methods to the category of preliminary exercises that laid the groundwork for more valued quantitative studies.

Aspiring to legitimize qualitative studies and give the method status equal to quantitative approaches (Glaser & Strauss, 1967, cited in Strauss & Corbin, 1998), Glaser and Strauss (1967) supported the argument that giving precedence to the hypothetico-deductive method (quantitative methods) meant that only existing theories that were quantifiable would be tested and re-tested. They deemed this approach to be restrictive and argued that it led to a gap between theory and research (Henwood & Pidgeon, 2003). Quantitative methods were further criticised as findings that were seen to have little relevance to real world problems (Henwood & Pidgeon, 2003).

Glaser and Strauss came from different philosophical and epistemological backgrounds. In their original GT method, they had attempted to merge those backgrounds. Glaser (1967), with his alliance to positivism and his strong background in empirical research, developed the systematic method and emphasised emergent discoveries. He argued in favour of a single reality that could be discovered and that the data spoke for itself. According to Glaser, meaning/reality was inherent in the data for researchers to discover, and this reality was separate from the researcher (Byrant & Charmaz, 2013). He viewed the findings of GT studies as a representation of reality and deemed its

findings as being grounded in the data; hence the name Grounded Theory (Fassinger 2005). In accordance with positivist assumptions, the researcher was deemed to be a passive, objective and neutral agent in the research process. In response to the criticisms of qualitative research (in particular issues of replication), he developed the rigourous and systematic method of coding and analysing data (the constant comparative method, an iterative process of data analysis).

Strauss incorporated the relativist assumptions of Symbolic interactionism and Pragmatism, in which the focus is on interactions and meaning (Charmaz, 2009). According to these perspectives, the individual lives in a social world of 'learnt meaning' (Herman & Reynold, 1994), in which the individual interacts with her or his environment using language and communication to form structures (Blumer, 1969, cited in Alidiabat & Le Navenec, 2011, pp. 1603). Therefore the manner in which individuals act/interact towards 'objects' (an object can be physical, social or abstract objects) is dependent on the meaning that the object holds for them. Some meanings are pre-existent within cultural groups (Seibold, 2010). Thus, the individual is seen as an active agent who uses thought as a tool for prediction, action and problem solving. Ultimately Strauss incorporated subjectivity into the GT method. Some years later, Glaser and Strauss differed in their opinions of the underpinning ontological and epistemological basis of GT, and each put forward his own alternative perspectives of the Grounded theory method (Walker & Myrick, 2006). Both discussed GT from the perspective of their epistemological backgrounds; Glaser presented GT from a positivist paradigm, whilst Strauss remained true to Symbolic Interactionism.

However, irrespective of whether one follows the Glaserian or the Straussian approach there remain some fundamental aspects of GT (Bryant & Charmaz, 2013). For example, the aim of GT is to discover and explain social processes, i.e. how participants develop meaning within a given context, and to explore the factors that influence and

shape meaning (Charmaz, 2008). At the time, GT was presented as a systematic method of analysing data that could be replicated in other studies. GT was and still is an inductive process whereby the researcher begins with generalised ideas, which are constantly compared to the data, and ends with a hierarchy of conceptualised categories and sub-categories (Glaser, 1978, 1992). Bryant & Charmaz (2013) identified the basic tenets of GT as 1) involving the constant comparative method (which is inductive and iterative in nature), 2) constructing analytical codes and categories from data and not from pre-existing theories, 3) simultaneous data collection and analysis (this forms part of the iterative process which furthers the analysis and shapes the research process), 4) advancing theory development through each stage of collection and analysis, 5) using memo-writing to develop more abstract and theoretical categories, 6) using theoretical sampling for the purpose of theory construction rather than aiming for representativeness and 7) conducting the literature review after developing the theory as a means of reducing the possibility of researcher bias. The end product of the GT method is the development of a theory that describes and explains a phenomenon. The level of saturation will determine how well the theory is able to do this.

3.3 The Constructivist Grounded theory approach

As mentioned earlier in the chapter, based on the changes in views about reality and truth, Grounded theory has evolved. Some of the biggest critics of Positivism were those who subscribed to the social constructivist perspective. The following sections will discuss the basic tenets of constructivism and detail how it shaped GT.

3.3.1 Constructivism

Constructivism stems from relativism, which is embedded within a subjective epistemology. Constructivists argue against an objective reality, stating that truth and

knowledge are constructions of the mind (Ghezeljeh & Emami, 2009). Constructivists believe in the existence of multiple realities. There is also a rejection of the concept *dualism* (the idea that there is a separation between knowledge and the knower) and instead claim an on-going interaction between the "knower" and "what can be known"; one cannot be separated from the other, as they are deemed to be fused into a coherent whole. Knowledge cannot exist independently of the knower (Norton, 1999).

The consequence of rejecting dualism is the creation of ambiguity, and the distinction between ontology and epistemology becomes murky, rendering all knowledge (and truth) subjective (Mills et al., 2006). On that basis, each individual's experience of events will be unique to them, increasing possibility for multiple realities to exist, as each individual will develop or construct his own 'version of reality'. However, some realities may be shared amongst groups (Heath & Cowley, 2003). Thus what has been termed as objective truth in positivistic terms is deemed a "shared reality" within constructivism (Ghezeljeh & Emami, 2009). Furthermore, each individual is influenced by her history and cultural context, which moulds the way in which the individual views her experiences (Mills et al., 2006).

Constructivism assumes that each individual is born into pre-existing cultural meanings that shape the individual's worldview and experiences (Charmaz, 2006). The construction of meaning allows individuals to make sense of their worlds and their experiences (Mills et al., 2006). This sense-making provides the individual with knowledge that can be used for the future making the world a much more predictable place. According to Strubing (2004), assumptions tend to be generalised statements based on individual experiences (cited in Bryant & Charmaz, 2007, pp. 556-557). Therefore, the nature of truth and the acquisition of knowledge are heavily dependent on the knower (Strubing, 2007). Knowledge, therefore, is constructed by the knower (Lo, 1996).

Numerous branches of constructivism have emerged, with subtle but distinct differences in the manner in which they think that meaning is constructed. For constructivists, meaning-making is a cognitive process, whereas for a constructionist, meaning is constructed through social interaction (Andrews, 2012). It is noted here that Charmaz adheres to the latter outlook (Charmaz, 2014). She argued that although there was a consensus that reality was socially constructed social constructionists did not necessarily apply these beliefs to the researcher or research practice (Charmaz, 2008). So instead she adopted the term constructivist grounded theory to differentiate her revised method from other Grounded theorists.

The researcher's own values are aligned with the humanistic approach, which, similar to social constructivism, does not adhere to positivist beliefs (Rogers, 1961; Perls, 1969; Maslow, 1962; McLeod, 2007). The constructivist perspective is in line with this researcher's personal and professional views about reality and truth. The humanistic approach values the unique experiences of the individual as well as the interactions between the practitioner and the client (Mcleod, 2007). Having become acquainted with the various GT methods, the decision to adopt the constructivist grounded was based on its close fit to her own beliefs. Matching philosophical underpinnings of research with one's own belief system is supported by Mills et al. (2006), who recommends such practice and in doing so one is able to increase the strength of the research (Mills et al., 2006, p. 4).

3.3.2 Constructivist Grounded theory

The current study adheres to a relativist ontology and constructivist epistemology. The chosen methodology followed Charmaz's revised GT social constructivist method (see Table 1 for a list of the underlying assumptions). According to Charmaz, social constructionism is inherent in the GT method, as Strauss and Corbin (1998) were

associated with Symbolic interactionism, which is a social constructivist perspective. In more recent years, Charmaz (2007, 2008, 2009, 2010; Bryant & Charmaz, 2013) criticised the original GT method for not taking into account the role of the researcher within the research process. While Glaser & Strauss (1967) saw the researcher as a passive, objective and neutral observer, the current study views the researcher as *acting upon*, *interacting with* and *making interpretations* of the data (Charmaz, 2014). That the researcher is an integral part of the research process, acknowledges the roles of prior knowledge, preconceptions and subjectivity on data analysis and collection. According to Charmaz (2008), theory and the research process are constructed by the researcher, and the researcher is influenced by interactions with her social environment. Based on these assumptions, the research process itself was seen as a social construction. Therefore the researcher could not be objective about the theory or data (Higginbottom & Lauridsen, (2014).

Box 1: Underlying assumptions of Constructivist Grounded theory

- Reality is multiple, processual and constructed, but under certain conditions
- The research process emerges from interactions
- The researcher and participants positionalities are taken into account
- Researchers and participants co-construct the data
- Data is a product of the research process

Taken from Charmaz (2007: p. 13)

Constructivist grounded theory still adheres to the basic tenets of the original method. Thus the strategies of the method were relatively similar to those of Glaser and Strauss (1967). However, where they differed was in the emphasis placed on the role of the researcher. Throughout the research process, it was essential that the researcher considered her own subjective world, and remained aware of how her own subjectivity impacted the construction of the research (Mills et al., 2006). In practical terms, this meant the researcher did not discount her own subjective experience, but rather, took note of her own process of interpretation as she progressed through the research, in the

form of memos, a reflective journal that incorporated reflexive (see Section 4.11, *Reflexivity).* This reduced the impact of the researcher's own biases on the research.

Also, as the construction of meaning was deemed to be context-specific, it was vital that the researcher embedded herself in the context of the phenomena under study (Ghezeljeh & Imami, 2009). The researcher was employed within the organisation from which the participants were recruited. This allowed the researcher to experience the natural setting of the participants (Chiovitti & Piran, 2003). It is important to note that the researcher did not have any personal or professional relationships with the participants selected.

As the participant and researcher interacted during interviews, together they co-construct meaning. As Strauss and Corbin state (1998), individual perspectives are defined, developed, negotiated and contested through interaction. In this way, the researcher became the *'author of the reconstruction of the participant's experiences'* (Mills et al., 2005). Together the researcher and the participant developed a shared understanding of the phenomena under study. As the researcher began to analyse the data, that shared understanding was iteratively compared and contrasted with the interviews of other participants. Ultimately, once the analysis was completed, what remained was a theory that accounted for the experiences of all involved (Charmaz, 2008). From the perspective of the Constructivist Grounded theory, therefore, theory was seen as having been generated, not discovered, due to the co-construction of knowledge (Henwood & Pidgeon, 2003). The next chapter will present the methods.

CHAPTER FOUR: METHOD

4.1 Overview

The following section will discuss how the methodology was applied through the research process. It will explain some of the key components of GT (i.e. constant comparison, theoretical saturation and theoretical sampling) in more detail and how these shaped the study. Also provided are details the recruitment, data collection, ethical considerations and procedure for analysis Furthermore, it will provide a reflexive account of the decision-making throughout the study, and lastly, it will evidence how saturation was reached with the use of examples. Permission was obtained from participants to include extracts of the transcript within the main body of this text. The rationale for the method can be found in the appendix.

4.2 Aims

The research aims to provide a theory that can describe and explain the experience of the transition from Child and Adolescent Mental Health Services (CAMHS, a specialist NHS service) to AMHS (Adult mental health services) from the perspective of all stakeholders. For the purpose of this study, stakeholders are identified as professionals, service users/young people and family members.

4.3 Participant selection and sample size

The selection criteria involved recruiting stakeholders in the transition process. This resulted in multiple groups: mental health professionals, young people and families.

The selection criteria were intentionally broad in order to increase the likelihood of recruiting sufficient participants. There were a total of 8 participants in the study.

In comparison to quantitative methods, sample sizes are generally much smaller in qualitative studies (Mason, 2010). Sample size is closely linked to saturation. Saturation is defined as the point at which no new data emerges and recruitment stops, (Charmaz, 2014). Section 4.9.2 provides more discussion regarding saturation. Therefore the aim here was not to recruit large numbers of participants, but rather to ensure that there was enough data to assure the researcher had identified all possible codes, concepts, dimensions, properties and categories (Mason, 2010). This means sample size cannot be predetermined in qualitative studies.

4.4 Participant recruitment

The initial stages of recruitment involved purposive sampling with broad criteria. Alongside this, snowball sampling was also adopted; where participants were recruited through word of mouth. The details of the strengths and limitations of these methods can be found in Chapter Six, Section 6.3, *Critical appraisal.* The latter method led to the recruitment of one participant whose primary role was that of a transitional worker. Both methods of sampling are consistent with grounded theory method, as they each allowed the researcher to identify potential participants based on their relevance to the phenomena under study (Coyne, 1997).

Requests were made via email to current and ex-trainees from the practitioner doctorate course, and requests were also made to the British Psychological Society (BPS). (See Section 4.7, *Ethical considerations*, for a more detailed account). The email contained a flyer that provided details of the research purpose and method, a consent form, details about withdrawal from the study and information on how to gain a copy of the findings. The participants were asked to contact the researcher directly via email (see Appendix

5). All contact details were provided on the flyer. Once the participants expressed interest, they were contacted either via email or over the phone to arrange the date, time, and the venue of the interview. All interviews were conducted within NHS premises.

The initial stages of recruitment yielded four participants in total. The experience of working with young people or young adults ranged from 4 to 16 years. Following the analysis, the need for further data collection and analysis became apparent. At this point a decision was made to continue data collection in order to further elaborate and refine the categories. (See Sections 4.4 and 4.9.2 *re* 'theoretical sampling' for further details.)

In the second round of recruitment, the researcher once more obtained ethical approval from the Faculty Ethics Committee and through IRAS, the NHS ethics approval system. A decision was also made to return to the NHS trust that had been approached in 2012, and local research governance approval was again granted. Participants were recruited via theoretical sampling (see Section 4.9.2). Participants were identified based on their ability to expand, enrich and supplement the already existing categories. This led to the recruitment of a Nurse specialist who had experience working in both CAMHs and AMHs, an Eating disorder nurse specialist, a parent of a young person who recently been referred to AMHs, and lastly a young person who had made the transition already.

Table 1: Participant role and workplace

Participant	Role	Service	Number of interviews	Duration of interviews (total in mins)
Participant one	CBT Therapist	AMHs – IAPT service	1	41
Participant two	Therapeutic education worker	CAMHs –Tier 3 plus	1	58
Participant three	Psychological therapist/ Transitional worker	CAMHs - Tier 3	2	57
Participant four	Counselling Psychologist/ Joint lead of Psychology	AMHs – secondary care	2	49

Participant five	Nurse Specialist	CAMHs –Tier 3	1	75
Participant six	Young person		1	47
Participant seven	Specialist nurse	CAMHs – Tier 3	2	90
Participant eight	Parent		2	126

All participants received information packs sent via email, with a covering letter containing an overview of the project and detailing the procedure for participation. Information about consent and withdrawal were included, together with a consent form for participation in the interview, and also a notification that the interview would be audio-recorded. Potential participants were also informed of how a summary report of the findings could be provided. Participants were assured of confidentiality and anonymity.

4.5 Ethical approval

Ethical approval was granted in 2012 by the University and NHS Ethics Committees (see Appendices 2 and 3). Once both granted approval, information was then sought in order to identify the possible participants.

4.6 Ethical considerations

All efforts were made to ensure that the study was compliant with the ethical codes of conduct for conducting research with human participants, as detailed in the British Psychological Society's Code of Human Research Ethics (BPS, 2010). At all times, the research was conducted with integrity and respect for all involved in the study, which included the participants and service providers.

4.6.1 Consent

Consent was gained in writing from all the participants (see Appendix) prior to the interviews. Consent involved agreeing to take part in the study and for interviews to be recorded. To ensure participants made an informed choice, they were each provided the same information about the study. The researcher made time available to answer any participant queries before the interview. An information sheet provided details about the aim and purpose of the study, the length of time required to participate, and the fact that all personal details would remain confidential in order to protect participants' anonymity. All personal data was securely stored, and only the researcher had access to this data. Lastly, all the participants were made aware in writing that they were free to withdraw from the study at any point.

4.6.2 Confidentiality and Anonymity

During all stages of the research, efforts were made to ensure that the confidentiality and anonymity of participants were maintained. All documents with confidential information, such as letters, are scheduled to be destroyed five years after the completion of the study. While the study was underway, these papers were kept in a secure and lockable drawer, where only the researcher had access to them. The transcriptions contain the names of participants, but with pseudonyms used instead of their real names. No identifiable documents were stored on the hard-drive of any computer or laptop. All such documents were stored on a password protected USB, which was locked away when not in use, and only the researcher had access to it.

4.6.3 Other Ethical Issues Addressed

During the data collection and the writing of this study, all efforts were made to ensure that the research did not leave participants feeling distressed or in discomfort in any

way. This was done by being sensitive, non-judgemental, respectful, and by actively listening to the participants' needs and circumstances throughout the research process. The researcher and the research were transparent, open, and honest about the nature of the study, the procedure and analysis. Measures were taken to ensure the accuracy of any information that was provided by the researcher. If they experienced some form of discomfort at any time during the study, they were given the option to either continue or end the interview by withdrawing their consent without consequence. By doing so, the researcher respected the rights of the participants. However, no participants withdrew from the study.

In case they wished to withdraw from the study at any point, participants were made aware that they were free to do so at any time. Consideration was also given to the risks involving the organisations. The study showed respect to the service provider at all times. The communication of any research findings would not be damaging or bring the service into disrepute.

Lastly, thought was given to researcher responsibility if 'poor or mal-practice' was disclosed during the interview. For the purpose of this research, any practice that was not in accordance with the BPS code of conduct or the HCPC code of conduct would be considered bad practice. Although this did not occur, depending on the severity of the disclosure, the researcher would have acted in accordance with BPS professional guidelines. In such circumstances, the researcher would have either discussed the disclosure with the participant outside of the environment of the study, or alternatively, informed line or service managers, depending on the severity.

4.7 Data collection

4.7.1 The use of semi-structured interviews

For this study, it was decided to use semi-structured interviews with all stakeholders as the main method of collecting the data. Once the first set of data was collected, the analysis began. The use of semi-structured interviews permitted the researcher to have a standardised set of focussed questions to explore the topic under study. The use of semi-structured interviews was consistent with GT, as there is flexibility of including probing questions to follow new lines of enquiry (Duffy, Ferguson & Watson, 2002). According to Duffy, Ferguson and Watson (2002), focussed questioning is consistent with the GT method, and is already an inherent method of interviewing particularly in the later stages of analysis, when questioning is driven by the emerging theory.

Semi-structured interviews allowed for sufficient time and space to ensure that the interviewer was able to explore the participants' experiences in detail and depth, so the researcher was able to gain insight into the world of the interviewees (Whiting, 2008; Qu & Dumay, 2011). Social constructivist grounded theory emphasises the importance of the relationship between researcher and participant (Charmaz, 2014). The researcher followed recommendations provided by Qu and Dumay (2011) whereby an effort was made to create a relaxed and comfortable environment, use active listening skills, and adopt a non-judgmental attitude. This approach allowed the researcher to build rapport with the interviewees which is a vital practice in research interviews (Whiting, 2008). For example, the researcher made efforts to maintain good eye contact, to not interrupt the participant, and to leave the space open so that participants felt free to use the time to reflect and discuss topics that were significant to them. Creating such an environment reduced the power imbalance that can occur, thus reducing the chances of participants trying to please the researcher with their answers. Additionally, the use of providing

feedback, either in the form of nodding, agreeing, and paraphrasing, demonstrated that the researcher was actively listening. The use of open-ended questions in the interview schedule allowed the researcher to maintain some degree of focus and control whilst leaving room to explore new lines of enquiry (Qu & Dumary, 2011). Another benefit of using semi-structured interviews is that it offers the participant some guidance, as a totally unscripted interview could be difficult to conduct and potentially lead to confusing, incoherent, and ultimately meaningless data (Smith, 2008).

4.7.2 Interview schedule

The interview schedule (see Appendix 4) was seen as a flexible tool for data collection and was developed based on the research question. As the focus was on the experiences of participants making the transition, the questions focussed on actions that stakeholders engaged in throughout the process. In order to capture the social process over time, questions were also asked about experiences before, during and after the transition in the hope that they would elicit action over the course of the transition. Efforts were made not to impose preconceived ideas and to ensure the interview guide remained as neutral as possible (Charmaz, 2014). To facilitate an exploratory approach, open-ended questions were used. Consideration was also given to how the participants might perceive the interview questions, and at times questions were revised on this basis.

As the theory began to develop and data collection became more refined, the interview schedule was amended. Questions honed in by following lines of inquiry that would expound categories. Amendments to the interview schedule were guided by the analysis. A copy of the interview schedules and amendments made can be found in Appendix 4, Interview schedule.

4.8 Analysis

The analysis followed the guidance of Charmaz (2000; 2007; 2013; 2014). A more detailed account of the analysis can be found in Section 4.10, *Analytical procedure;* here I will provide a brief overview. There were three phases to the analysis, *initial coding*, *focussed coding* and *theoretical coding*. In layman's terms, coding involves "naming segments of data with a label that summarises, categorises and accounts for each piece of data" (Charmaz, 2007, p111). The purpose of coding is to make analytical sense of the data. The inductive nature of coding means that the researcher starts with the specific codes and raises this to a more generalised conceptual level (Charmaz, 2007). Coding shapes the analysis, by eliciting codes that form a framework for further analysis, all the codes are grounded within the data (Charmaz, 2014). According to the social constructivist approach, codes are constructed by the researcher (Charmaz, 2014), and it is necessary for the researcher to demonstrate and practice reflexivity (Charmaz, 2014). For a full account of the reflexive process see section titled Reflexivity (Section 4.11). Although the phases are presented here as distinct and separate, there was a significant amount of overlap. Plus the iterative nature of GT meant that the researcher moved in and out of these phases numerous times.

Initial coding, involved coding of the raw data, here codes remain short, concise and descriptive and as close to the raw data as possible (Charmaz 2014). The aim here is to code action within the data, this was supported by the use of Gerunds (Charmaz, 2014). A gerund is a noun formed from a verb by adding 'ing'. Coding during this phase involves a critical stance, whereby the researcher questions the data, as well as their own preconceived ideas. In order to do so, the researcher made use of memo's and reflexive journals (examples of these can be found in the analytical procedure and reflexivity sections 4.10 and 4.11). In this early phase, codes were provisional, and the researcher sought codes that best accounted for the data, which then meant being open

to all possibly lines of enquiry (Charmaz, 2007). Best fit was determined by how well codes captured of the meaning or essence of the data (Byrant and Charmaz 2013).

Focussed codes, were codes identified in the earlier phase that seemed to have more significance or were high in frequency (Charmaz 2014). Here analysis involved working with larger chunks of data. Significance of codes was based on those which made more analytical sense (Charmaz, 2007). Here, concepts began to emerge from the analysis and codes became more conceptual (Charmaz 2007). During this phase the researcher also sought relationships between initial codes. Relationship were formed based on concepts that appeared to emerge from the data, this is another example of the inductive nature of analysis. The concepts in some cases were used as labels to group initial codes together. The researcher then returned to the data, to ensure that concepts were grounded in the data. Throughout this phase, the aim was to capture the essence of the phenomenon, and this formed the criteria for determining adequacy of focussed codes. Those which were perceived to have analytical power were the codes that were considered in order to further analysis. Coding for concepts, gave the focussed codes more depth and breadth, thus accounting for more of the data (Charmaz, 2007). Here coding resulted in tentative categories, once these emerged there was an overlap between focussed coding and theoretical coding phases.

The third and final phase of analysis was that of theoretical coding. Here analysis involves critically analysing the data and codes, from a theoretical perspective (Charmaz, 2014). The codes formed here began to move the analysis into a more conceptual level that was able to provide an in-depth understanding and explanation of the phenomenon under study (Charmaz, 2007). The concepts that had emerged in the earlier phase were further explored in order to piece together the story of participants experiences (Charmaz, 2014). According to Charmaz, theoretical coding aids making links between focussed codes (Charmaz, 2014). The analysis begun to identify more

generic processes, through which the researcher was able to identify and name categories. Here the coding phase made use of theoretical memo's; which furthered the analysis beyond mere description and towards a theoretical framework or theory (Charmaz, 2014). Through this process, the analysis led to the identification and definition of categories, properties and dimensions.

4.8.1 Constant comparison method

The method has been defined as:

"…a method of analysis that generates successively more abstract concepts and theories through inductive processes of comparing data with data, data with categories, category with category, and category with concept" (Charmaz, 2007, p. 607).

Following this method at each stage of the analysis meant that every new idea, insight, code, or category that emerged was compared with all the data. The constant comparative method served the purpose of ensuring that insights were grounded in the data and were not impositions of the researcher. This process was also followed when making tentative inferences; the constant comparative method was applied throughout the analytical process, from the initial codes through to theoretical integration. As the researcher began to code the transcripts, she developed a greater understanding of the phenomenon under study. This enabled the researcher to develop a sense of theoretical sensitivity. Theoretical sensitivity is defined as 'the ability to recognise and extract from the data elements that have relevance for your emerging theory' (Mills & Birk, 2011). According to Mills and Birk (2011), theoretical sensitivity has three characteristics: the personal, professional and experiential history of the researcher; the techniques, tools and strategies to enhance theoretical sensitivity, and lastly, theoretical sensitivity throughout the research. By developing a better understanding of the researcher's influence on the research through the use of techniques and strategies such as the

constant comparative method, reflexivity and memo writing, the researcher was able to further develop a more integrated and abstract theory.

The emergence of negative cases was another indicator that the researcher had made attempts to account for variation within the data. These cases refer to incidents in the data that did not fit the developing theory or contradicted existing categories, sub-categories or properties (Charmaz, 2014). For example, 'accommodation' was noted as a sub-category of 'ironing out the differences'. In the earlier stages of analysis, the code 'too rigid' had been identified and referred to incidents in the data where AMHs were seen as being too rigid with eligibility, which created difficulties. Initially the code 'too rigid' was considered to be a dimension that related to the property differences between services. However, as data collection and analysis continued, there emerged a description of AMHs having accepted the referral of a service user below their age criteria. (A more detailed account of the analytical process can be found in the section analytical procedure.) This was an incident in the data that contradicted the original interpretation, which was subsequently revised to include the negative case, thus leading to a more refined interpretation that was able to account for more of the data.

All of the above gave the researcher a degree of confidence that firstly, she had considered variation in the data; secondly that she had accounted for its influence on the data; and lastly that she had consistently followed the Grounded Theory method. Although saturation was not reached, a significant factor for deciding to cease data collection was based on analysis of the later interviews, where minimal changes made to the existing theory. Other peripheral factors were also considered such as the limited resources such as time constraints and slow uptake of participants.

4.8.2 Theoretical sampling and theoretical saturation

Recruitment and selection was guided by the concept of theoretical saturation. Theoretical saturation is the point where researchers have defined, checked and explained relationships between categories, dimensions and properties. New incoming data does not yield any new ideas, insights, or interpretations, nor does new data challenge the definitions and properties of the existing categories or their relationships (Charmaz, 2014; Bryant & Charmaz, 2007). Theoretical saturation was used as a means to judge when to cease data collection and analysis. The extent to which saturation was achieved also serves as a means of demonstrating the rigour of the study. Charmaz (2006) considered saturation to be a guiding principle, and reaching theoretical saturation is the goal for grounded theory studies (Charmaz, 2014).

Judgements about the degree to which saturation was reached were based on consideration of a number of factors: accounting for all possible explanations, the emergence of negative cases, the use of the constant comparative method, theoretical sampling, and abductive reasoning. Within the current study, theoretical saturation was not reached to 100%. However, appraisal of the factors mentioned suggested that the categories were sufficiently populated to support credible theory generation and therefore that the degree of saturation was acceptable. In the remainder of this section, the author will demonstrate the level of theoretical saturation. Overall, the discussion will demonstrate how each of these factors limited the number of assumptions and inferences required when looking at the tentative theory.

From the analysis of the first set of interviews, it was evident some of the clusters of open codes were still more descriptive than analytical. The categories had not been saturated and in order to further expand and refine the developing theory, there was a need for further data collection. The recruitment of participants then became more selective, and the identification of participants was based on who would be able to add

to the existing theory. Where categories were deemed to be lacking in depth and breadth, questions were formulated focussing on explicating the categories. This form of sampling is termed *theoretical sampling* (Charmaz, 2014). In order to raise categories to a more conceptual level it as necessary to be able to define the properties and dimensions more fully and this required further interpretative analysis. To illustrate, the example of organisational factors is used, what seemed to have more analytical power was the concept of tension arising due to organisational factors. Therefore, tension with the organisation, became the next line of enquiry that was pursued in subsequent interviews. This also identified the next sample group to be professionals, as they would be able to expand, supplement and challenge the existing category of organisational factors. The focus on this line of enquiry also led to amendments of the original interview schedule (see Appendix 4, *Interview schedule*, for details).

Theoretical sampling differed from the purposive sampling strategy used in the initial recruitment process. The initial sampling was about identifying a starting point for the exploratory fieldwork (Charmaz, 2014). Theoretical sampling was the strategy adopted to add more clarity to, or new insights into, the phenomenon under study. However, the aim of theoretical sampling was not solely to achieve saturation (Charmaz, 2014). In the context of this study, theoretical sampling was used as a strategic, specific and systematic method of developing theory (Charmaz, 2014). It is considered unique to grounded theory (Charmaz, 2014). Once the categories began to emerge, theoretical sampling facilitated a more focussed approach to sampling and data collection. Using theoretical sampling meant the researcher actively sought people, events, or information that would expand, supplement and challenge the existing categories by eliciting what was not said as well as what was (Charmaz, 2014). The theoretical sampling process allowed the researcher to check out hunches and formulate emerging ideas more fully (this can be likened to adding meat to the bone). The process helped to distinguish

among categories, clarify their inter-relationships, and identify variations and exceptions that needed to be understood or explained before proposing a theory, as the theory needs to have predictive power.

As theoretical sampling refines the developing theory, there should come a point where further data collection and analysis does not add anything new to the theory. This inevitably also determines the sample size required (Charmaz, 2014). At this point the theory is deemed to be robust, as the data has been exhausted enough for the theory to stand on its own without being altered by any new data (Birks & Mills, 2011). This was evidenced in the latter stages of the analysis. After having analysed the eighth interview, there were very little changes to the emergent theory. This suggested the study had gathered sufficient enough data to saturate categories, meaning the study was very close to saturation. Furthermore the use of theoretical sampling gave confidence that the method remained consistent with grounded theory and the sampling approach enhanced the rigour of the study.

The degree of saturation was further evidenced through the presentation of a clear and comprehensive audit trail (see Section 4.10, Analytical procedure) and also with the use of memos and reflexivity (for a discussion of the latter, refer to the Section 4.11, *Reflexivity).* Memos form a record of how ideas and interpretations developed throughout the analytical process, from initial codes through the theory development. Memos were documented in the coding book (coding book has been provided on a CD for reference). The coding book was also used to record the researcher's own views and perspectives. It aided in raising self-awareness, thus enhancing reflexivity (Charmaz, 2014). The coding book also aided the use of the *constant comparative* method. Below is a flow chart detailing the process of analysis and data collection.

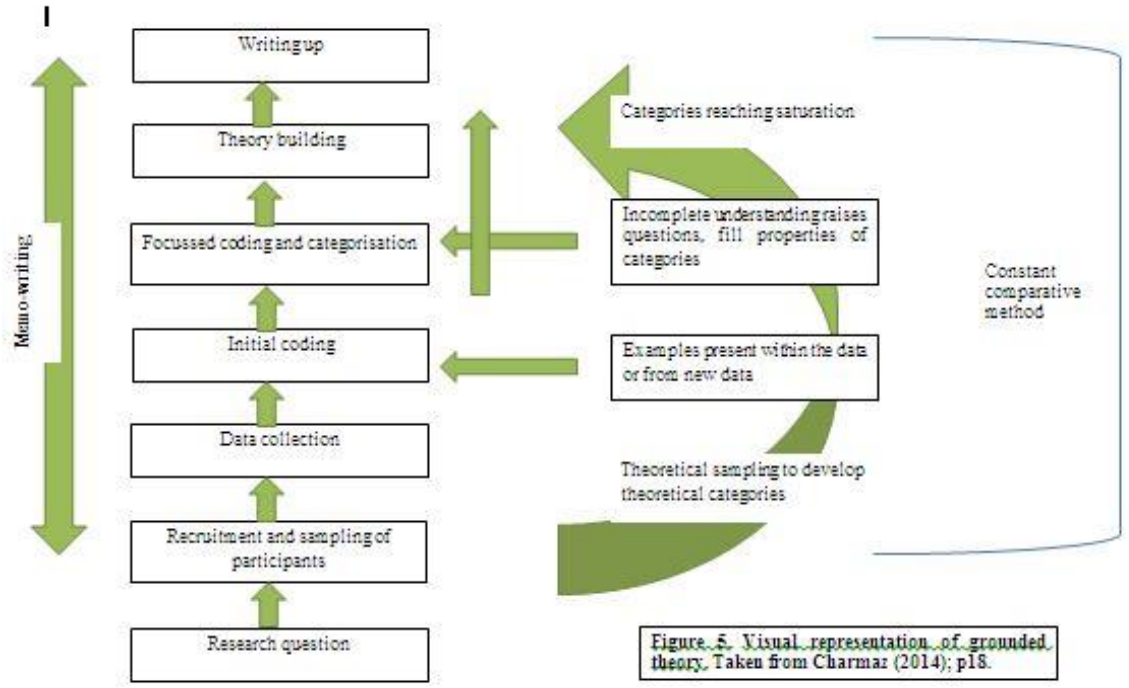

Figure 1: Visual representation of grounded theory

4.9 Analytical procedure / audit trail

This section will provide a detailed description of the analytical procedures that were undertaken to elicit the findings. As stated in the earlier sections, the analytical procedure followed the constructivist grounded theory method as described by Charmaz (2006, 2007, 2008, 2014). For ease of reading, this section will be written in the first person.

Analysis in grounded theory is an iterative process of coding, constant comparison and data collection and does not necessarily flow in a linear fashion. However, the purpose of this section is to demonstrate the development of the theory, so, for ease of reading, I will discuss the analytical process in a linear fashion. The section is divided into the three main phases of analysis), *initial coding, focussed coding* and *theoretical coding* (Charmaz, 2014). Each section describes my understanding of the coding phases as well as how analytical decisions were made throughout. For the purpose of demonstration, I

focus on the specific category '*manoeuvring the boundaries',* and describe how the emergent process of analysis led me from the transcripts to category development.

4.9.1 Transcribing the interviews

Transcription refers to the process of 'reproducing the spoken word' (Halcomb & Davidson, 2006, p. 38). A decision was made to transcribe the interviews myself. Transcribing interviews provided a record of the interviews, which was revisited multiple times to review, revise and formulate ideas. Others have suggested only using field notes, written during and after interviews. However, this method of recording raw data was not deemed adequate. This view is supported by Charmaz (2014), who described the sole use of field-notes as being based upon an unsupported assumption, as one cannot guarantee one has documented all possible lines of enquiry. Although I did make use of field-notes, they were used in conjunction with the transcriptions.

Typing the transcriptions became an integral aspect of the analytical process, as I was able actively to immerse myself in the data, as advised by Charmaz (2014). This allowed me to enter an analytical space where I could focus solely on what I observed in the data. From this vantage point, I was able to review and listen for possible codes or potential lines of inquiry. Each interview was transcribed word for word, and also included non-verbal communication such as pauses and changes in inflexions. I had interpreted these as evidence that participants were talking about topics that were of significance. As I listened to the interviews, I also recorded my initial observations, thoughts, feelings and perspectives in memos, which were used later in the analysis.

4.9.2 Initial coding

Each transcript was analysed *line by line* in the beginning, to ensure all data was treated equally. The first phase of analysis involved coding the transcribed text. The use of

codes allowed for the data to be organised and sorted, so that comparisons could be subsequently made (Charmaz, 2014). I attempted to read the text critically, and not simply accept the narrative of participants at face value. Analysis was initially guided by my interest and the research question. Eliciting participants' experiences of the transition process was the springboard from which I commenced analysis.

In this early phase of the analysis, I read and re-read the transcripts numerous times, focusing on eliciting action and meaning in the data, not themes or topics. These initial observations formed the basis of the initial coding process. Coding is defined as the breaking down of data into distinct units of meaning (Charmaz, 2014). In order to focus on actions, I followed the guidance of Charmaz, who suggested the use of gerunds (Charmaz, 2014; Glaser 1978). A gerund is a noun formed from a verb by adding 'ing'. An example of this is where participants spoke about ethical struggles with concepts such as duty of care, responsibility, respecting the client. I could have labelled the code 'ethical dilemmas', but this is a static code, and does not identify the action or process. Instead I identified the action related to ethical dilemmas and hence labelled the code, 'managing ethical dilemmas'. This moved the analysis towards describing what was actually happening (processes) in the data as opposed to making concrete statements or naming topics and themes. In this earlier stage of analysis, it was important that I remained as open as possible to all lines of enquiry. The significance of codes was not known at this stage, and so all codes were treated as possible lines of inquiry for further analysis. This resulted in codes that were short and simple, and efforts were made to remain close to the data. The close link between the data and the final theory can be seen in that a number of the codes used in the final theory are in fact *in vivo* codes; these codes are extracts of words or phrases taken from the transcripts (Charmaz, 2014). Codes were also deemed provisional, and were subject to change, particularly if the code constructed did not fully account for what was happening in the data. In such

cases, codes were revised to ensure a good fit; a good fit was determined by how well the codes were able capture action and meaning. The table below provides examples of initial codes identified through the above process.

Table 2: Examples of initial Codes

- AMHs sticking to boundaries
- being boundaried leads to difficulties
- considering age of client vs service age boundary
- being flexible
- negotiating with adults would be better
- Considering ethical dilemmas
- nearing service age boundary
- Not discriminating against age
- Young people repeat storying
- Services overlapping

In addition, I also considered my role as researcher and how I might be influencing the analysis (see Section 4.11, *Reflexivity).* For instance, I aimed to be critical about the use of language when labelling codes, and how this shaped the understanding of the text. For example, I made note of everyday words, such as *coming together* and *overlapping,* which were used to describe how the services met at the point of transition, and so at first glance they could be referring to the same thing. However, I did not assume I understood the meanings that participants gave to these terms, and instead searched for definitions and possible alternative meanings. Where alternative meanings existed for the same word, I matched the definition with the context in which the word was used. This method was consistent with a constructivist approach, as the language that we use can evoke pre-existing meanings, values and views. I made efforts to illicit my own pre-existing meanings as well as pre-conceived ideas, initial impressions or observations, and recorded them with the *use of memos* (an example of memos has been presented in Table 4, below; see Appendix 1 for the coding book.) These were viewed as another perspective, to be used in the analysis. The table below is a worked example of initial

coding. It identifies the codes along with the text from which it originated. Box 2 is a memo that was used to further the analysis of initial codes.

Table 3: Initial coding--worked example

Extract from Interview five (professional participant)	
J –and my experience is that they very much stick to the boundaries and its 17 in terms of _____ and that's it. So that leads on to difficulties because again using the choice appointment as an example…..then when they come to choice at say 16 and 10 months or 11 months I think we're almost looking if possible to do a mental health screening and a risk screening and….and you know if possible not taking the case forward because we would do that with anyone. It's not equitable. We'd do that with anyone but that is a consideration that…well actually if they need something else obviously we're going to see them way past 17 and it's going to be more difficult. But as I say we wouldn't operate that kind of view on just that age group it's the same across the board, but it's an extra thought. Well if they need something else then they are going to be in our service…..so yes….going back to the original point a degree of flexibility or negotiation would be far better.	• AMHs sticking to boundaries • being boundaried leads to difficulties • considering age of client vs service age boundary • screening mental health and risk at assessment • rejecting referral • not equitable • seeing young people past age boundary • anticipating difficulties later • being flexible and negotiating with adults would be better
G – Sorry, I just wanted to go back to the point you just made earlier because it was quite an interesting point. You talked about a dilemma and you talked about a duty of care which could be seen as kind of ethical dilemmas that you're talking about. Are there other ethical dilemmas that occur? And how do they play a role? J – Well it's the same with all the work we do…but whilst considering with this topic in particular. This transition. you…your ethical dilemma is that you know a young person is coming up to 17 however you can't do something different for that person because...if you like you can't discriminate against them because of their age….and that plays a	• Considering ethical dilemmas • Knowing young person nearing service age boundary • Being equitable • Not discriminating against age • Trying to be flexible with adult services • AMHs assessing young people • Services overlapping • Young people having to repeat story

part in your thinking and you know….I think we do try and have that flexibility with the adult services and also if you look at things like erm…issues around assessments of young people if they've been in the service, if they've come for a choice appointment and heading towards transition then for the young person even if you transition them quite easily then they'll still have to go across and tell their story to someone else. ok…you'll have it documented but…but you know…from experience of when you pick up a case that someone else has sent there is some overlap….you are starting slightly back you know…back….so for the young person they may have to tell their story or concerns again. which makes it….with that overlap it's not quite so seamless	'starting slightly back' • Not quite seamless

Box 2: Example of a memo

Memo

He is talking about several significant things here:

- The tension between service boundaries and ethical practice
- Young people having to repeat their story
- Being inflexible - AMHs

In the text above, it seems that he identifying an underlying 'tension'; between the ethical codes of conduct and the service boundaries. How do professionals then manage these tensions?

He states how this can make things difficult, but does not explicitly say how difficulties arise. He seems to have given an example but to me he had brushed over things somewhat. I feel there is an underlying sense of frustration (I felt this throughout the interview also). From his description I wonder if he feels like, 'CAMHs are left carrying the baby' so to speak. Although he doesn't use the word rigid he refers to how AMHs needed to be more flexible. So the unspoken here is that AMHs are 'rigid', if AMHs are rigid with their age criteria, and a service user enters the CAMHs late, AMHs will not see them until they have reached the age of eligibility. So what happens with the young person in the meantime? Do CAMHs offer intervention? How do CAMHs professionals feel when faced with this situation? Also what happens with the tension? Does it influence the transition?

He also talks about being boundaried, whereby AMHS will not accept referrals of young people who are below their age criteria. He refers to this as AMHs being inflexible, judging by the context in which he has used this term (not just in this section but all throughout the interview); being inflexible is not a good thing. I wonder what being flexible would mean? How would this be better? I wonder what would happen if AMHs were more flexible?

If AMHs were more flexible isn't there a danger that the boundaries could be blurred, I mean where would services draw the line? Boundaries are there for a purpose, they provided structure and all organisations need some form of structure. The boundaries in

this case serve the purpose of determining the eligibility of the young person to access a service.
Another interesting point that he raised was the overlapping of services, he talked about young people having to repeat their story. What is the significance of this? He is alluding to this as a difficulty? How does this make the transition difficult and for whom? How do young others feel about repeating their story?

After each transcription had been coded for initial codes, the next phase of analysis, focussed coding began.

4.9.3 Focussed coding

Focussed coding is the second phase of the analytical process. It involved analysis of the initial codes. Those that had strong analytical directions were defined as focussed codes (Charmaz, 2014). Judgement about the significance and adequacy of codes was based on codes that were seen most frequently in the text or those that seemed to be able to account for more of the data. Focussed codes were more conceptual than the initial codes. A critical stance was achieved by not passively reading the data, by asking questions, by being reflexive and by using the constant comparative method. Where inferences were made, they were made tentatively; any codes that were inferred were then compared with the data to ensure their fit and relevance. The constant comparison of codes with the data also increased confidence that I had not imposed them based on my own pre-conceptions or assumptions. In addition I employed reflexive practice throughout the study; as described in Section 4.11, *Reflexivity.*

To support my analysis, I developed a coding book in a word document. Each page was been divided into 4 boxes; each box contained a single initial code, along with memos related to that code. Codes were analysed individually by revisiting the text from which the code had originated and asking questions of what I observed in the data. I then compared each code with all the data and looked for patterns. This led to identifying

relationships among multiple codes. These links were labelled accordingly and formed the focussed codes.

Through this process, I was also able to identify properties, and in some instances, dimensions. For instance, following on from the extract above, the participant had spoken about 'being boundaried' in relation to the age criteria. Participants spoke about how boundaries were established based on age and diagnosis. He later went on to describe how he believed AMHs were too rigid with their age criteria. There were numerous references to 'being rigid' throughout his transcript. I compared 'being rigid' to the transcripts of other participants and began to ask questions of this code, such as 'are there any other incidents where services have been described as rigid'; 'what is the significance of being rigid', and 'what is the consequence of being rigid'. Critical questioning of the codes provided analytical direction. The code was deemed to have significance and analytical reach, and so 'being rigid' was defined as a focussed code for further analysis. In this early stage, I was not able to foresee or predict which codes would be raised to focussed codes, or which would form the building blocks of a category, and so each code was analysed following the process stated above. Once focussed codes had been identified and labelled, I revisited transcriptions to check that the code could account for what was seen in all the data.

Simultaneously, I also checked the code 'being rigid' and compared it with other codes. This process revealed a link between 'being rigid' and another code, 'being flexible'. I interpreted these as two opposites of the same thing, as they were both used to describe *how* professionals interacted with the boundaries, i.e. they were described as either 'too rigid' or 'too flexible'. I then looked for both codes in the transcript to ensure that I had clearly understood the context within which they were used. At first I had thought that these codes were specific to maintaining the boundary between services. However, as I continued to sift through codes and transcripts, I found a code, where AMHs had been

flexible with the age boundary. This incident contradicted what other participants had said, that AMHs were rigid, and so it was identified as a negative code. I considered the impact of this negative code. It put into question the capacity of the two codes (being rigid and being flexible) to account for all of what was happening in the data. I had a sense that the two codes were dimensions of something, as they seemed to be identifying a range. I continued to make comparisons between codes. What eventually transpired was that the two codes 'being rigid' and 'being flexible' were linked to incidences in the data where participants had experienced some difficulty with the transition, and depending on the outcome, participants either described AMHs as 'rigid' or 'flexible'. This led to another line of inquiry. I began to look at incidences of difficulties as well as how participants managed them. This led me to the code 'accommodation'. Accommodation was another *in vivo* code. It referred to one of the strategies participants used to overcome difficulties throughout the transition process (to be discussed in more detail in Section 5, *Discussion and findings).* Through the use of memo writing, I started to form ideas about the tentative links between accommodation, being rigid and being flexible. I consequently elevated 'accommodation' to the status a 'property' with 'being rigid' and 'being flexible' as its dimensions. This highlights the inductive nature of grounded theory, as the analytical process raised the initial codes to a more abstract and conceptual level.

This process was repeated until every code had been given the same level of critical attention. Through analysing and organising the data in this way, I was able to identify further relationships between codes. After having classified accommodation as a property, I then began to mine the data for other strategies participants used to deal with or manage difficulties. This illuminated the relationship the following codes, 'identifying roles and responsibilities', 'creating similarities between services', 'sharing information', 'joint working', 'understanding each other', 'making joint decisions' and

'applying ethical principles'. I interpreted each of these to be the strategies of professionals to manage difficulties, and so clustered them under the heading 'Ironing out the differences'. In addition, I also began to look for incidences of difficulties, and made the decision to move away from the use of the word 'difficulties', which is more descriptive, and began to code for concept 'conflicts'. A discussion about the reasoning behind this change can be found in Section 4.10.4, *Naming the category.*

By this point, the tentative category, Ironing out the differences, had subsumed initial codes. The category had begun to become saturated with data. I had coded the actions of participants, i.e. the strategies they used to manage conflicts. The coded actions of professionals formed the defining characteristics of the category, and so were labelled properties (see table below). The dimensions were the range of those characteristics.

Table 4: Category development

Tentative Category	Property	Dimensions
Ironing out the differences	Accommodating	• Being rigid • Being flexible
	Identifying roles and responsibilities	• Clear roles • Blurred roles • Not knowing roles and responsibilities
	Creating similarities between services	• Easing them in • Feeling the difference
	Sharing information	• Sharing information • Not sharing information
	Joint working	• Working in isolation • Sharing the care package
	Understanding each other	• Knowing the service structure/ making sense • Lacking knowledge about services/ not making sense
	Making joint decisions	• Different agendas • Joint decisions • Not making decisions together

	Managing ethical dilemma's	• Being boundaried • Making informed decisions • Having professional responsibility • Maintaining therapeutic boundaries • Maintaining contact after transition • Maintaining confidentiality • Respecting the client

At this stage it was not known whether ironing out the differences would remain a category. The label given was also an *in vivo* code, which evidenced to me that I had not imposed the category and that it was grounded in the data. The usefulness of categories was determined by their ability to explain and offer understanding of the phenomena under study. Categories were deemed as being saturated when they were able to account for large chunks of data with few assumptions or inferences. Furthermore, a sampling method specific to grounded theory, theoretical sampling, was used to further expand and refine the developing theory. (For a more detailed account of both, please see Section 4.9.2, *Theoretical saturation and theoretical sampling.)*

As I mined the data for incidences of managing conflicts, I searched for conditions under which conflicts arose. Returning to the data and initial codes, participants primarily attributed difficulties to the differences between services. By sifting through the codes, I organised the differences between services in terms of their differing 'cultural beliefs', 'working practices', 'sharing of responsibility' and 'levels of support'. What surfaced was that the differences between the services were conflictual. On this basis, I clustered the service differences into separate code from ironing out the differences; labelled 'conflicting cultures'. This further supported my decision to consider conflict as a code, as the term seemed to account for more of the data, and

encapsulated the disagreements between ideas, beliefs, practices, and people, all of which were seen in the data. As I continued to search, I was led to other examples of conflicts that were not related to the conflicting cultures. This led to the grouping of the codes 'communication', 'imposing support' and 'cultural differences'. They were all interpreted as points of conflicts that arose during the transition process, and so they were grouped together and labelled 'points of conflict'. In this early phase of the analysis, conflicts were also perceived as barriers to the transition process. This became a significant consideration when naming the category.

Thus far I had developed relationships between tentative categories which explained the differences between the two services (Conflicting cultures), how those differences created conflicts (Points of conflict) and how conflicts were overcome (Ironing out the differences). Analysis, had moved from describing the data, to dealing with emergent concepts that were more theoretical in nature e.g. communication, conflict, support. The importance of these theoretical codes became more evident in the next phase of coding.

Table 5: Sub-category - Points of conflict

Tentative category	Properties	Dimensions
Points of conflict	Communication	Poor Lost in translation Clear
	Imposing support	Refusing to transition Refusing to discharge without support Needing on-going support
	Conflicting cultures	Child vs adult perspectives Dyadic vs triadic relationships of responsibility Individual vs systemic working Intensive vs less intensive

Critically inspecting the developing category, what I had not elicited was *how* stakeholders experienced the conflicts, so I returned to the coding book. This demonstrates the inductive and iterative nature of the GT process. Throughout the analysis, I was constantly moving up and down the phases in a cyclical fashion, starting with the general (initial codes) and moving into the specific (theoretical codes). In the search for codes related to how stakeholders experienced conflicts, I noted that I had already identified 'anxiety' as a code, as anxiety was seen to permeate the transition process. I made links between the codes 'containing anxiety', 'conflicting cultures' 'creating conflict' and 'ironing out the differences'. Participants expressed an awareness of a theoretical link between anxiety and experience of change. They also explained the degree of anxiety associated with the transition was influenced by the level of conflict. So at this stage, I speculated whether the tentative categories could be inextricably linked to each other, and whether there was potential for them to be subsumed by another higher order category. This was the point where I had begun the process of naming the category.

4.9.4 Naming the category – Manoeuvring the boundaries

In the previous phase, a number of tentative categories had been identified. Here the categories were further refined and developed by the use of theoretical codes (Charmaz, 2014). This led to grouping the tentative categories discussed in the last section under a heading that was able to subsume more of the data. The remainder of this section was written using of some of the theoretical memos that I had written at this phase of the analysis. The section describes how I moved into a more conceptual level by discussing concepts that added richness, depth and breadth to the developing theory. These concepts formed the conceptual links. Below details a discussion of concepts and how they were critically analysed in order to inductively code and name the category.

In very early versions of the theory, the concepts ’conflict’ and ‘barrier’ were interpreted as being interlinked. My interpretation of their relationship developed as I progressed through the analytical process. The relationship was defined thus: the differences between services created barriers; barriers had the potential to create conflicts during the transition process; when conflicts occurred, stakeholders described their experience as difficult. So my focus in earlier phases of analysis was on eliciting codes related to barriers. However, the analysis led me to deconstruct the meaning of the words in order to determine their ‘relevance’ and ‘fit’. When taking this into consideration, the word ‘barrier’ related to ‘*preventing something from occurring’.* I compared this meaning to the data. Although participants spoke about the existence of barriers, there were instances in the data where, in spite of barriers, people still made the transition. There was a sense of fluidity and movement in the process. Conflicts seemed to disrupt but did not prevent transitions from occurring. Additionally, the term ‘barrier’ is often associated with an object or structure *being in the way* and *acting as an obstacle*. This appeared, in a sense, to suggest a barrier as being somewhat *static*, which again did not account for the movement seen in the transition. This was not to say that barriers didn’t exist, as there was evidence to suggest otherwise, but rather that barriers were a *part* of the *whole,* and not the whole itself; they accounted for the conditions but the not the actions.

The term barrier also relates to a *structure* blocking access. Viewing the meaning of the word barrier as a *structure* appeared to fit with what was observed in the data, as the structure within the context of this study included things like the two services, the organisation, policies, procedures and legal frameworks. These are not easily moveable, avoidable or changeable throughout the transition process. Additionally, the organisation is *static*, as it is relatively stable and fixed. Although change does occur, when it occurs, it is usually gradual. Therefore, ‘barrier’ was deemed to be a significant

concept that carried some capacity in explaining part of the transition process; and so I continued to follow this line of inquiry. Each concept was given due consideration, similar to that which was detailed above.

Having deconstructed the meaning of the word 'barriers', the code conflicting cultures (which relates to the organisation) had the potential to act as a barrier to the transition. By default, thinking about the transition in terms of barriers then led me to logically question, what was facilitating the process? After having looked for facilitating factors, what emerged was that the same concepts that acted as barriers in one incident were a facilitating factor in another. Further analysis of *barriers* and *facilitators* eventually led me to the *action* in the data associated with both concepts. There was evidence of three sets of actions in the data, *decision-making*, *acting on those decisions* and *reactions to those decisions*. A differentiation is made here, as *acting on* referred to the planned actions and '*reactions to'* were defined as a consequence. I began to explore the data, looking for all three. What came to light was that conflicts could arise at three distinctive phases in the transition (pre-transition, during the transition and post transition), and at each phase, participants talked about managing some form of conflict that arose out of barriers (which some participants also referred to as 'challenges'). Although the system had the potential to act as a barrier and prevent transitions, there were also instances where their transition had occurred with little difficulties and others where barriers had been hindered or created delays to the process. I queried what had made the difference? In this case, the actions that professionals took in order to avoid or reduce the impact of relatively static barriers were uncovered. In following this line of enquiry, what became more apparent and what seemed to have more influence on the process were the *actions* that professionals took as a means to *manage* those barriers, as well as their reasons for doing so.

Bearing the above in mind, considering the concept of *conflicts* seemed more fitting, as this had more breadth in its definition and could account for more of the data. Conflict by definition relates to things and/or people being incompatible, disagreements, a state of mind and a prolonged struggle. There was evidence of each of these. The word *manoeuvre* by definition relates to the *controlled and skilled action* or *movement that allows one to change one's course*. This seemed to tally better with what was observed, and hence a decision was made to use the word in the major category. The word 'manoeuvre' seemed to capture the dynamic interaction between *thought* and *action*. It also depicted the motion involved, of having to manoeuvre and navigate across the boundaries of services. When faced with barriers, it was how participants were able to either overcome or move around them that seemed to influence how the transition was experienced.

Thinking about the transition in terms of the movement (i.e. *manoeuvring*), opened up questions about how and why participants took a particular course of action over others. This then led to me to look for incidents of *decision making*. After mining the data, what emerged were the variables that participants took into account when making decisions, how and why decisions were changed (which looks at barriers and facilitators), and how these decisions then influenced the actions of the participants. This resulted in a comprehensive description and explanation of the transition process that was also grounded in the data. Therefore, it was how professionals were able to manoeuvre across the boundaries through the process of decision-making that made a difference to experience, rather than overcoming barriers. Hence, the major category was defined as 'manoeuvring the boundaries'. See Figure 2 (p. 96) for a visual representation of the finalised category.

4.9.5 Theoretical coding – Piecing the theory together

I continued with this iterative process of comparing data with data, codes with codes, codes with data, codes with categories, categories with data and categories with categories. Where gaps existed, theoretical sampling was used to further develop and refine the category. As I progressed through the analysis, I had begun to develop what is referred to as 'Theoretical sensitivity' (Charmaz, 2014). Charmaz defined this as 'the ability to understand and define the phenomena in abstract terms and demonstrate abstract relationships between studied phenomena' (Charmaz, 2014, pp. 160-161). At this phase, codes that were deemed as having little significance or little analytical power were discarded. Those that remained were considered to be the most significant, as they were able to describe and explain the experience of transition. In the earlier phase, the categories that had 'carrying capacity' were selected as categories; carrying capacity refers to the ability of the category to subsume more codes, thus accounting for more of the data (Charmaz, 2014).

By this point, the categories contained theoretical concepts, such as conflict, adulthood, childhood, adjustment, accommodation and responsibility, which gave the developing theory more depth, breadth and explanatory power. Each of these were abstract conceptual codes, which not only moved analysis into the theoretical realm but also aided in the development of theoretical sensitivity. Theoretical sensitivity was also influenced by the researcher's existing knowledge and background, as one can only name and code conceptually based on one's pre-existing knowledge. Concepts were not forced or imposed, but rather earned their way into the theory, and so were seen as emerging from the data. Concepts emerged through the inductive process, as I had started with general observations (initial codes) and moved to the specific (focussed codes and concepts) (supported by Charmaz, 2014). Furthermore, the conceptual codes formed the thread by which the theory was joined together; it created a cohesive and

more incisive understanding of the transition process. I began linking concepts, as is consistent with Grounded Theory; I explored concepts to see which had the best fit and was able to further expand the developing theory.

During the focussed coding phase, I had identified a number of categories. However, the significance of each had not fully been established. During this latter phase of analysis, categories were organised into a hierarchy and categories were deemed to be either major or minor. Making the decisions about which categories would be raised to major category status was based on the suggestions of Charmaz (2014):

'We choose to raise categories because of their theoretical reach, theoretical centrality, incisiveness, generic power, as well as considering the relationships with other categories' (Charmaz, 2014, p. 247).

Each category contained a range of theoretical concepts that identified the relationships and helped to develop the storyline, thus providing an abstract understanding of the process. According to Charmaz, (2014), theoretical concepts (codes) form the building blocks of an interpretive frame that underpins the developing theory. Through this process, I had also tentatively identified three major categories: Manoeuvring the boundaries, Changing status and Reflections on the process.

Through comparing and contrasting concepts, as mentioned earlier, I had developed three major categories that accounted for the organisational factors (differences between services, how the differences created conflicts, how conflicts were resolved, etc.). Another category identified was 'Reflections on the process'. This category identified the meanings participants associated with the process, the organisations as well as some of the challenges that occurred at the interface between services. The last category was Changing status. This accounted for the intrapersonal factors associated with making the transition into Adult services. Each of these was deemed a fundamental process of making the transition. At this phase, I began to integrate the theory based on the

relationships between theoretical concepts; this allowed me to make connections between and within the three major categories. These relationships formed the structure of the finalised theory. Finally, to facilitate identification of the core category, I considered the theoretical centrality, reach and analytical power for each.

I had originally conceived shift of power as underpinning the whole process in earlier versions of the theory, as this seemed to have an influence throughout the transition process. Its influence could be seen on three levels (intrapersonal, interpersonal and organisational). As I continued through the analysis even more fundamental than the shift in power was the changing status of the service user. The young person moving into adult status was what triggered the transition. It also triggered the shift in power, and it was able to account for the individual, relational and organisational changes that occurred. The category seemed to effortlessly and intuitively subsume all other categories. Relationships were evident with the other categories as well as their sub-categories. However, following the iterative approach of GT analysis, I concluded that the transition was a challenging time with many changes occurring concurrently or in rapid succession. It seemed that professionals, parents and young people were expected to confront these changes with little preparation. However the changes presented each stakeholder with challenges/ difficulties/ tensions and conflict. As the analytic process continued, I concluded that the transition required each stakeholder to confront multiple and sometimes uncertain changes in expectations, service delivery and relationships without necessarily having a great deal of understanding or support. As with any change, the period of change is experienced as stressful and may be followed by a period of reflection. This led to the identification of the core category, ‘facing the transition’. This was deemed to have reach and centrality and was therefore named as the core category.

4.10 Reflexivity

Charmaz (2007) defined reflexivity as 'the generalised practice in which researchers strive to make their influence on the research explicit. Reflexivity is the examination of the researcher's interests; positions and assumptions influence his or her inquiry' (Charmaz, 2014, p. 344). Mills & Birk (2011) describe reflexivity as an 'active process of systematically developing insight into the work of the researcher' (Mills & Birk, 2014, p. 52). Social constructivists do not strive for objectivity, as the knower cannot separate himself from what can be known. Mallory (2007) argued that the research itself could be conceived of as a social process, where there is a bidirectional influence between researcher and participant. This is also supported by Cutcliffe (2003). By definition, then, reflexivity refers to the interaction(s) between the researcher and the research itself. Following a constructive grounded theory positions the researcher as an active agent in the research process. Researchers are influenced by their own life history, background, culture. They create their own value systems that influence how they view and make sense of the world. These values are also present whilst the researcher is engaged in the research process and can influence decisions made throughout.

In more recent years there have been debates about the usefulness of reflexivity in the GT studies. Some of the criticisms are based on positivist assumptions about objectivity and researcher bias (Gentles et al., 2014). Finlay (2002) stated that incorporating reflexivity creates a risk of shifting the focus of the research and blocking participants' voices (Finlay, 2002, p. 541). Cutcliffe (2003) argues that in a time-limited study, as most professional doctorates are, reflexivity can act as a distraction, as it takes the focus of the researcher away from the more 'intuitive selfless analysis', thus hindering the interpretive process. Lastly, Finlay (2002) argues that in spite of efforts to be explicit about the researcher's influence, it is not possible for one to have complete knowledge

of the self, and so one's level of insight will only be partial. Despite these criticisms, there is a growing acceptance of the use of reflexivity in GT studies (Koch & Harrington, 1998; Charmaz, 2014; Gentles et al., 2014; Hall & Callery, 2007). Those in favour have suggested that reflexivity is an essential criterion of rigour and trustworthiness of the study (Gentles et al., 2014). The social constructivist researcher positions herself as being an active part of the process and a co-author of the theory. Theory is derived through the interactive process between the researcher and the participant, and so the data is seen to be co-constructed (Charmaz, 2007). Therefore, researchers should not dismiss their own influences. Rather, social constructivists emphasise demonstrating how the researcher's preconceptions have shaped and influenced the research (Charmaz, 2014). This is deemed to increase the transparency, trustworthiness and ultimately the rigour of the study. Therefore a decision was made to present the following section, as it details how decisions were made, how the researcher influenced the research, and how the interaction between the researcher and participants shaped the study. The remainder of this section will be written in the first person for ease of reading.

4.10.1 Sampling and data collection

I had originally considered conducting semi-structured interviews with young people, families and professionals using an Interpretative Phenomenological Approach. However, in 2008 and 2009, after having conducted a preliminary literature review to ensure my study was not replicating any extant literature, I found that apart from one article, I could find no literature specifically exploring transitional care within mental health services. The lack of literature raised questions about how I could develop the interview schedule without prior findings to base it on. In order to use IPA, I felt I required some kind of framework within which to understand the topic and to then

develop the interview schedule. With little research to go by, this was challenging. I began to look at alternative research methods and came across the Grounded Theory approach. I had not previously been aware of this integrated methodology and method. At the time, my main reason for choosing the method was based on the knowledge that it was predominantly used when little was understood about a phenomenon.

At the time, I had a great sense of empathy for the experiences of young people and families as they made their way through the transition. Therefore my intention was to provide a platform for young people and families where they could openly and freely voice their thoughts and feelings. Methodologically, I had perceived this as enhancing the rigour of the study, as it would have enabled me to capture the experiences of all stakeholders. However, in practice, this proved to be more difficult than I had anticipated, as the initial recruitment strategy yielded only four participants, all of whom were professionals based in either AMHs or CAMHs. Having conducted all four interviews and while analysing the transcribed data, what emerged were gaps in the understanding of the transition process. These gaps were predominantly about the experiences of young people and families; their voice in the developing theory was minimal. For example, in the early stages of data collection, little was known about the experience of moving into adulthood, how it felt to end the therapeutic relationship and how parents felt about their lack of involvement. This then led to the decision to theoretically sample young people and parents.

At the same time as this occurred, I had secured employment within the NHS Trust where I had ethical approval. My position as employee enabled me to network with colleagues in the trust and provided me with the opportunity I needed to access service users and parents. I began to request meetings with the manager of the CAMHs team, and also met with colleagues to discuss my research. In doing so, I was able to recruit 5 more participants, 2 of whom were young people, 1 parent and 2 professionals.

Unfortunately, one of the young people recruited later withdrew from the study. In these later interviews, due to the difficulties in recruitment and the limited time I had left, I had decided to extend the interviews, with participant's permission, beyond the hour that I had originally agreed to in order to ensure that I had gained enough rich data to further my developing theory. I was also very mindful that participants might not be able to commit to another meeting, and so offered them the choice of either completing the interview on our first meeting or of meeting more than once. All participants stated they would prefer to complete the interview in one go. This influenced how I conducted the later interviews.

4.10.2 The interviews

During all the interviews, I was mindful of the interactions between the participants and myself. There appeared to be a perceived difference between the interviews with other professionals and the interview with the service user and parent. With the professional, there was a sense of familiarity, not on a personal note, as I did not know the participants beforehand, but in the sense that we were all professionals who worked in the mental health system. I believe this familiarity was based on the fact that they may have seen me as 'one of them', a front line staff working in the sometimes challenging environment of mental health system. This was true for me as well, so I became very mindful of the transference and counter-transference that was occurring during the interviews with CAMHs professionals. I did not distance myself, but rather made note of the things that the participants had assumed, as this allowed me to elicit the 'taken-for-granted' knowledge.

During all the interviews, I made efforts to follow the lines of inquiry that stemmed out of their responses. I focussed on things that seemed to be significant to them. My judgements about significance were based on their use of inflexions. I made note of

changes in their tone, pitch and pace, which I interpreted as them discussing something that was significant. As well as listening to what was said, I also made efforts to focus on what wasn't said, on subjects that the participant seemed hesitant about, or had brushed over rather quickly. Having worked as a therapist for 9 years (of which 6 years involved providing psychological therapies), I used my therapeutic skills to develop rapport with each participant. I offered to meet with all participants prior to the interview; this occurred for all but the young person due to her other commitments. This allowed us time to 'break the ice', so to speak. Throughout the interviews I made efforts to reduce the power differentials, particularly when interviewing the young person and parent, by encouraging them to ask questions, and by reinforcing that the research was about amplifying their perspective. I attempted to remain neutral throughout the interviews to ensure that I did not influence their responses to questions. Where my views or perspectives differed from the participants', I made a note. Those notes were used later in the analysis. I made efforts not to interrupt participants, and used strategies such as paraphrasing and summarising to show that I had listened. This also served another function in that it allowed me to check my understanding with them; where I had misunderstood, participants did correct my understanding. This demonstrated that they felt comfortable with me. The more comfortable they felt, the more comfortable I felt in asking more probing questions.

4.10.3 Data analysis

During the data analysis I made efforts to ensure that I was not imposing my own assumptions and preconceptions onto the data. A majority of the codes are *in vivo* codes (codes that are directly from the data), which demonstrates that the cods are close to the data. I made efforts not to assume the meanings of words. Instead I would look up definitions and match them with the context within which the words had been used.

Where inferences were made, I did so tentatively, and then compared the inferences with each of the transcripts for evidence that I had not imposed my own pre-conceptions.

Throughout the analysis, I followed the suggestions of Strauss & Corbin (1990), and asked standard questions such as, 'what is happening in the data', 'what do the actions in the data represent', 'in what context is the code or action used' and 'is the code related to another code' (Woolfe, Dryden & Strawbridge, 2007 p. 526). Asking standard questions ensured that each bit of the data was treated in the same way and increased the reflexivity of the researcher.

As is consistent with Grounded Theory, data collection and analysis occurred simultaneously. Throughout this process, I was mindful of the codes that I gave the data and how others would perceive the evolving theory. Therefore, as I progressed through the analysis and the structure of the categories and the overall theory began to take form, I began to incorporate questions about the categories, sub-categories, properties and dimensions into the interviews. Consideration was given to probing questions, to ensure they were not leading and also to make sure the questions were neutral. This served the purpose of checking my understanding of the participant's experience. This also gave me confidence in the analysis. In the later stages of data collection and analysis, I had developed a deeper understanding of participants' experiences. My sensitivity to the phenomena grew. At points in the analysis I found that the data was mildly conflicting with my own beliefs and experiences of supporting young people through the transition process. I noted this in memos. I began to recognise some of my own assumptions and pre-conceptions, namely, that I was somewhat problem-focussed. In the earlier stages of the research and data analysis stage, I had anticipated finding barriers to the transition as I had experienced barriers as a practitioner as detailed in the earlier section. I had not anticipated the possibility of identifying the strategies used by

professionals to support and facilitate the transition. This was clearly significant to professionals, as they tended to focus on how they overcame the barriers. Another assumption elicited was my perceptions about AMHs in relation to supporting the young girl. In my experience, mentioned earlier, I had questioned whether AMHs had done enough to support the young person. As I began to analysis the data of the adult services, I began to recognise my own naivety. The situation was much more complex, and the differences between the two services were in fact relevant and essential in order for the services to meet the needs of their service users. I began to develop more of an empathic stance towards AMHs, and recognised the difficult ethical dilemmas that arose for them throughout the transition process. Although participants did not discuss this in depth, I also recognised how the services were shaped by wider systems, e.g. the legal framework, ethical codes, and society in general. I had hoped to follow these up in subsequent interviews. However, these were illuminated late in the analysis, so I was unable to pursue these lines of inquiry at this time. They will provide useful pointers for further work.

4.10.4 Writing up

This research is conducted as part of the Counselling Psychology doctoral programme. Inevitably I had questions in my mind about how the research would be perceived by the participants and academic peers. These questions were also raised throughout the analysis and continued through to the write up. I had concerns about whether the participants would agree and accept my interpretation of their experiences. As mentioned earlier, I made use of memo writing to document my assumptions and also checked my interpretations with participants. This gave me confidence in the developing theory.

CHAPTER FIVE: PRESENTATION AND DISCUSSION OF THE FINDINGS

5.1 Overview

This chapter will present and discuss the findings of the study. In this section I have chosen to refer to myself in the first person. Amongst some scholars, this style of academic writing has been deemed 'irrelevant, disruptive and unacceptable'; in extremes it has also been considered an 'impediment' (Lupton, 1998; Stanley & Wise 1993, cited in Davies, 2012, p. 747). These arguments are based on positivistic assumptions whereby removal of the 'I' (and the author from the text) gives the impression of objectivity and impartiality, which are highly valued in positivism (Smith, 2008; Kirsch, 1994; Charmaz, 2007). Having followed a social constructivist grounded theory approach, which values the subjective nature of knowledge (Norton, 1999); the researcher was seen as an integral part of the research process (Charmaz, 2014). For qualitative studies, writing in the passive voice can be 'distracting for the reader' and render the writing as 'inarticulate and juvenile' (Fulbrook, 2003, p. 229). The chosen methodology and method promotes the use of reflexivity, and demonstrating this practice is considered to be a marker of rigour and quality (Davies, 2012; Charmaz, 2014). Therefore to eliminate the author, as typically seen in traditional (positivistic) academic writing styles, was deemed to be incongruent and in conflict with the philosophical underpinnings of the current study (Kirsch, 1994; Charmaz & Mitchell 1997; Logan, 2012; Davies, 2012). So, as a means to ensure fluidity and coherence, as well as a need to ensure the writing is harmonious with the philosophical underpinnings, the remaining sections are written in the first person.

5.1.1 Structure of the chapter

The chapter is divided into subsections; the first section presents the tentative theory. The core category is identified as 'facing the transition' and I will discuss its relationships to the other categories. The remaining sections break down each major category in turn, providing a more detailed explanation of the category in terms of properties and dimensions and its relationship to other categories.

5.2 The tentative theory

Figure 2 is a visual representation of the theory. The core category was defined as *'facing the transition'* and is surrounded by three major categories, *changing status*, *manoeuvring the boundaries* and *reflections on the transition.* The theory describes how the transition is psycho-social process that leads to a change on an intrapersonal, interpersonal and social level. Depending on how stakeholders appraised the change in circumstances was considered to directly impact the experience of transition.

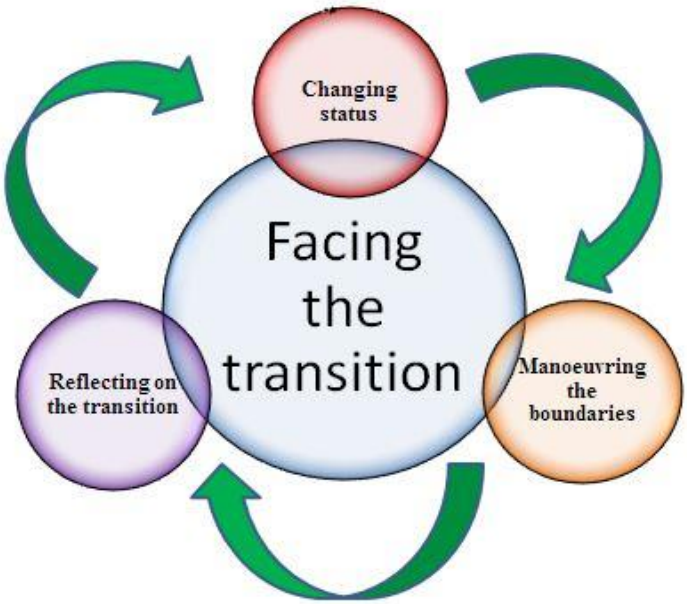

Figure 2: Facing the transition

5.2.1 Core Category: Facing the transition

The core category was defined as 'facing the transition'. This was selected as the core based on its centrality, i.e. its ability to connect each of the categories (Charmaz, 2014) . Throughout the analysis of the data, I gained a sense of participants managing a situation perceived as challenging and stressful. It appeared that the transition was a difficult time with multiple changes which, under certain conditions, presented barriers to stakeholders. It seemed that each stakeholder had to 'face up to', make sense of and adjust, not only the changing status of the young person (a normative developmental process), but also the change in services (service transition) and then make sense of the meaning of these changes for them as individuals.

According to participants, service users' needs should be at the forefront when planning and implementing the transition. In order to ensure effective transition professionals spoke about the need to account for the influence of both developmental and service differences, as each of these bring about significant change in the lives of young people. The developmental process is explained in the category 'changing status' and 'manoeuvring the boundaries' explains the service transition.

Based on the analytical process, the transition was interpreted as a period of change which, according to participants, required some level of adjustment. After any period of change, there is also a period of reflection or sense- making of the gains and losses inherent in any transition; the 'reflections on transition' by participants were captured in the third and final category. The dynamic interaction between each linked category either created tension or smoothed the path for service users as they made the transition. It was this inter-subjective relationship between categories which determined how the transition was experienced.

5.2.2 Changing status

The category, 'changing status' focuses on the journey from childhood to adulthood within the context of service transition. Through the analytical process changing status was perceived as having a significant influence on the transition and had two major implications: firstly it marked the young person's journey into adulthood and secondly, it triggered the transition. Participants described the normative developmental transition into adulthood in terms of being able to take responsibility for one-self, making autonomous decisions, and being independent (see section 5.4 Changing status). These characteristics are embedded within societal norms and the data suggested these norms influenced the expectations placed on young people facing transition. In the UK a child is redefined as an adult on their 18th birthday. However, participants described variation in the way that young people (and in some cases, parents) adjusted to their new status and the data in this research suggested there may be wide variations in the rate and pace of assuming independence and responsibility and being confident (or trusted) to have capacity to make their own decisions.

Participants noted that some young people are able to meet these expectations, as they have most likely developed the skills and internal resources to manage their new roles and responsibilities (see section 5.4.3. Adjusting to change). Participants described these young people as adjusting well to the developmental transition. In contrast those who lacked the necessary skills and internal resources were described as struggling to adjust and often reported feeling ill-prepared for adulthood when discussing the transition with their CAMHs worker (see section 5.4.3 Adjusting to change). How young people adjusted to their new adult status was considered to directly impact on the way in which they interacted with the service transition. Professionals involved in the study, therefore, spoke about a need to support young people through the developmental process, by making use of opportunities where young people could learn and develop

the necessary skills required for adult life (see section 5.4.2.3 Preparation for adulthood). For instance as a means to encourage young people to make more autonomous decisions, professionals talked through decisions, identifying options and costs and benefits of each. They also spoke of accompanying young people to meetings or appointments with AMHs until young people felt confident in accessing support independently.

5.2.3 Changing status and shift in power

Both professionals and the parents stated that there was a shift in power when the young person reached adult status, the analysis identified this as a consequence of both the service and developmental transition. In the context of this study, the term power refers to responsibility and authority to make decisions (see section 5.4.1 *Handing over*). Professionals stated that as the young person moves from one service to the other, there is a period of overlap, where both services will come together to discuss and implement the transition. During this overlap, because the young person is deemed to be an adult (i.e. they have reached 18 years of age), they are expected to now take on the responsibility and authority to make decisions about their own care and treatment. Based on the analysis of data, the shift in power was deemed to then lead to a shift in the relationships between the stakeholders i.e. service users, professionals and parents (see section 5.4.1.1 Shift in power). CAMHs participants spoke about how it is commonplace for parents to be involved with the care package. Professionals considered parents to have a role in decision-making about treatment in CAMHs. My interpretation of this was that it meant the transition led to change in the roles and responsibilities of the stakeholders i.e. parents are expected to relinquish their responsibility and authority to make decisions and that power is handed to the young person. Professionals, also described how the same is also true for them, where power

shifts from the CAMHs worker to the AMHs workers (see section 5.4.1.1, *Handing over).* Based on the data, I interpreted this to be a difficult and challenging experience for young people and parents. There were incidences in the text where some young people welcomed the change, whilst parents may be fraught with worry about their child's ability to cope and their own lack of involvement. For other young people, this appeared to be a daunting task, and participants described how young people may experience high levels of anxiety, (see section 5.4.3 Adjusting to change).

5.2.4 Changing status and Manoeuvring the boundaries

For those young people who were nearing the age boundary of CAMHs (defined by chronological age as either 17 or 18 years of age), professionals considered them to have outgrown the service. They went on to talk about how a number of those who are either 'at the age boundary' or 'nearing it' may still require on-going support from mental health services. In most case, participants reported that the service transition was instigated at least 6 months to a year before the service user reached the age boundary. Upon reaching the age boundary, the systems (i.e. services) deemed the young person to be an adult, irrespective of developmental stage, and are required to make the transition from CAMHs to AMHs (see section 5.3.1 Deciding to transition). However, participants reported that difficulties tended to arise due to the fact that not only do some young people not feel ready for adulthood, but the two services have different cultures, resulting in differing working practices and expectations of service users. These differences can become a point of conflict during the transition, and are discussed in more detail in Section 5.2.6 of this chapter and for an account of the differences between services see section 5.3.4.

From my analysis, the most notable difference appeared to be that both services viewed the same young person as being at different developmental stages (see section 5.3.4

Differences between services). Based on the data, CAMHs typically viewed young people as 'emerging adults' and AMHs viewed them as 'adults'. Through the analytical process, I identified subtle but distinct differences between the two; of most significance was the difference in perceptions about responsibility, capacity and competence of the service user. It seemed that when a young person moved into AMHs there was an expectation that young people are independent and will have the capacity to take responsibility and make autonomous decisions about their treatment. However, as mentioned in section 5.2.2 and 5.2.3 not all young people will have developed the skills necessary to fulfil these expectations. This view was commonly expressed by CAMHs workers and was described as a point of frustration. The difference in status accorded to young people had the potential to create conflicts, raise anxiety and act as a barrier to transition; thus delaying the process.

5.2.5 Manoeuvring the boundaries

From the analysis, this category was considered to set the scene of service transition by describing and explaining the actual transition itself. In order for service users to cross the boundary, participants described how there is a point at which the two services must meet, this is where a majority of the conflicts arise due to the cultural differences between the two services (see section 5.2.3, Changing status and Shift in power, and also sections 5.3.4 Difference between services; 5.3.5 Points of conflict). This category focuses on; the process of decision-making throughout the transition (section 5.3.1 Deciding to transition); how and under what conditions conflicts can arise (see section 5.3.4 Differences between services, and section 5.3.5 Points of conflicts) and; how professionals manage those barriers and consequences (see section 5.3.6 Ironing out the differences and section 5.3.7 Containing anxiety). Based on the participant data, it transpired that conflicts can occur within any of the three categories and the experience

of the transition was determined by how professionals identified and managed those conflicts.

In the initial stages of the transition professionals assess the need for transition through a clinical assessment of the young person's needs, depending on the outcome, a referral will be made. Barriers and conflicts can arise in these initial stages, primarily due to the varying criteria and thresholds between to the services, meaning that some of those seen in CAMHs will not meet the threshold or criteria for AMHs. The next phase, involves the two services working together to agree and implement the transition plan. However, each service is structured in accordance to the needs of their client groups; this creates both subtle and major differences. Therefore professionals face a number of challenges and it is how they manoeuvre around the service differences [i.e. boundaries] that influences the experience of the transition.

This requires professionals to interpret and make sense of the various aspects of the transition process as well as considering the intrapersonal processes that occur simultaneously. Therefore professionals must take into account factors related to the intrapersonal (i.e. changing status), inter-personal (changes in role, responsibilities and relationships), the system (the transition) and the dynamic relationship between all three. Considering these factors enabled professionals to anticipate possible conflicts and anxieties and ultimately allowed them to skilfully plan and execute the transition, whilst still supporting young people and families in the process.

5.2.6 Manoeuvring the boundaries: conflicting cultures

One of the major barriers in the transition was the conflicting cultures between services (5.3.5.1.1 Conflicting cultures). Participants from CAMHs discussed how they followed a 'systemic' approach, meaning they view the family as a single unit. Often, supporting the mental health needs of the young person involves working with the whole family.

Participants explained that the service user is viewed as an emerging adult; participants described how young people at this developmental stage were still semi-dependent on the adults in their life. Therefore professionals in CAMHs talked about having to understand the child [service user] within the context of the family. According to the CAMHs clinicians, work in CAMHs involved working with parents as well as with other agencies e.g. schools. Therefore professionals in CAMHs expressed the importance of understanding the child [service user] within the context of the family.

On the other hand, AMHs viewed service users as an adult, who has personal responsibility. Therefore AMHs professionals reported not including parents in decision making as they have a duty to maintain confidentiality and also promote and respect the autonomy of the individual (see section 5.3.6.7 Managing ethical dilemmas). Therefore in AMHs, responsibility is shared within a dyadic relationship, typically between service users and the service. In CAMHs responsibility is generally shared within a triadic relationship, between the service, parents and young people. This change in dynamics can be anxiety provoking for both parents and young people. As a result stakeholders try to make sense of their changing circumstances.

5.2.7 Facing the transition: Conflicts, adjustment and changing status

Analysis of the data led me to conclude that conflicts and barriers can arise depending on how each stakeholder adjusts to both their changing status and the implications of such changes. Implicit in the process is a period of adjustment, which not only relates to the young person and parents but was also perceived to extend to professionals in CAMHs, who have to give up their power and responsibilities at the point of transition. However, for them the adjustment was more about letting go of the client, and for most of the professionals, there was a certain level of anxiety about what will happen to the young person once they are no longer involved (see section 5.5.1 Intrapersonal

processes). Therefore I considered this category as providing an explanation regarding how the shift in power created changes to the relational dynamics, which required a period of adjustment. Depending upon how stakeholders adjusted directly influenced the experience of the transition process.

5.2.8 Reflections on the process

The third major category, is my interpretation of participants reflections on the process. The analysis identified the relationship between the individual (i.e. the intrapersonal processes) and the system processes. The intrapersonal and the system were perceived to meet at the interpersonal level. My analysis revealed that how individuals felt about and made sense of the transition determined how they interacted with the system as well as the professionals within it. My interpretation of the participant's stories was that the transition meant something different to each stakeholder (see section 5.5.1 Intrapersonal processes). For young people it meant becoming an adult, for parents it resulted in an evaluation of their role as a parent and for professionals it was about fulfilling their role as a practitioner. The findings seemed to suggest that the experience of the transition was dependent on how stakeholders evaluated the changes brought about by the transition. Meaning, if stakeholders evaluated the experience in positive terms they generally attributed positive feelings to the transition and vice versa.

This process of reflection usually occurred within the therapeutic relationship the young person has with their CAMHs worker (see section 5.5.2 changes in relationships). This was another major influence on how the transition was experienced. In most cases, young people reported feeling saddened at having to end the therapeutic relationship. A significant finding here was the relationships that CAMHs professionals had with parents. As stated earlier, CAMHs professional work closely with parents, because of

issues around responsibility and consent to treatment. In some cases, parents are emotionally supported by CAMHs professionals and have developed a relationship of trust with the CAMHs worker. Similar to young people the ending of this relationship and knowing they will have little to no involvement in their child's treatment can be daunting and anxiety provoking.

Finally, the theory also encapsulated my own reflections of the data in the sub-category see section 5.5.3. 'other considerations'. It discusses how participants highlighted an element of bureaucracy in the transition process, whereby the professionals are expected to follow procedures and protocol. Although often essential, as it provides structure for large organisations such as the NHS, during the transition my interpretation of participants' accounts led me to conclude that the system can be somewhat uncompromising. Participants described how professional colleagues can engage with the transition as a 'tick-box exercise'. This understanding of the transition process seemed to inevitably influence the experience of the transition for each stakeholder. To me this seemed to be because the protocol/ procedure for making the transition does not account for the 'lived experience', and focuses more on ensuring that professionals are working within their remit and that referrals are meeting criteria.

The remainder of this chapter will define and expand on the tentative theory by detailing, the sub-categories, properties and dimensions of the major categories.

5.3 Manoeuvring the boundaries

This category that I present here refers to the processes that occur over the course of the transition. The sub-categories are defined as: (1) *'deciding to transition'*, (2) *'making the transition',* (3) *'Differences between services',* (4) *'points of conflict',* (5) *'identifying the gap',* (6) *'containing anxiety' and* (7) *'ironing out the differences'.* Sub-category (1) identifies the first stage of the transition where professionals are

ascertaining whether a transition to AMHs is required. This sub-category focusses on the decision making process that occurs in the initial stages. The second sub-category (2), explains the actions that professionals in CAMHs undertake when making the referral. Sub-category (3) describes and explains the differences between services as described by participants. Sub-categories (4) and (5) explain how and why the difference between the services created conflicts and disrupted the transition. A consequence of making the transition is that it raises the anxiety of the stakeholders, thus sub-category (6) describes how anxiety arises and how it is managed. Lastly, sub-category number (7) describes the actions taken by professionals from both services in order to limit the impact of conflicts.

Table 6: Manoeuvring the boundaries and sub-categories

Category	Sub-categories
Manoeuvring the boundaries	Deciding to transition Identifying the gap Initiating the transition Differences between services Points of conflict Ironing out the differences Containing anxiety

5.3.1 Deciding to transition

This sub-category defines the process of decision-making that occurred in the initial stages of the transition. The dimensions for the property are listed in the table below.

Table 7: Deciding to transition and properties

Sub-category	Properties
Deciding to transition	Considering age Identifying the need Continuity of care Identifying the diagnosis Considering risk Meeting criteria

In layman's terms these properties were the factors that directed decision-making. It was the cumulative effect of these factors on the mental health of young people that appeared to influence and steer decisions.

> "…it was decided that we would actually keep her in CAMHS because of all these things I mentioned, mainly her presentation and the risk plus she was going to be on a waiting list...she got referred at a I think very late in her 17th year… and then she was seen only seen when she was nearing her 18th birthday and …there was that whole issue around that and…" (Participant one, page 4, paragraph 16)

At this stage early stage of the transition, the professional is not aware of whether a referral will be made. It seemed to me the aim in these early stages was predominantly about identifying need. I will discuss each of the properties and their dimensions in more detail and illustrate the complexity of what seems to be a relatively simple process on the surface.

5.3.1.1 Considering age

Participants described how the age of the young person was one of the main factors that triggered the whole transition. The dimensions are listed in the table below.

Table 8: Considering age and dimensions

Property	Dimensions
Considering age	Nearing the age boundary At the age boundary Passing the age boundary

I had interpreted age to be one of the main criterions that determined eligibility for both CAMHs and AMHs. Age also marked the boundaries of both services.

> " …we don't take on any referrals after 17. The year they turn 17 and 3 months. That's the cut-off point and then we don't see them after their 18th birthday" (Participant one, page 3, paragraph 24)
>
> "…you've got to wait till they're 18 but we finish at 17…" (Participant two, page,17 paragraph 171)
>
> "….we are getting a lot of, not 16 year old, but children who are just turning 17 and 17 onwards" (Participant four, page 1, paragraph 8)

When a young person was either nearing, at or had passed the age boundary for CAMHs. At this stage if on-going support was required, a referral to AMHs was considered. Below is an extract illustrating this.

> "…we felt she did need that extra support that CAMHs can no longer give her…"(Participant seven, page 19, paragraph 90)

The dimensions to this property were defined as *nearing the age boundary*, *at the age boundary* and *passing the age boundary.*

5.3.1.2 Identifying the need

Identifying the need referred to making decisions about whether or not the young person required on-going support. Table 9 lists the dimensions.

Table 9: Identifying the need and dimensions

Property	Dimensions
Identifying the need	Not needing on-going support Needing on-going support (short term) Needing on-going support (long term)

In cases where young people needed on-going support but only in the short term, CAMHs professionals talked about how this became a reason for not making a referral.

> "…because of where she was in therapy and we felt that we just needed probably another three or four months to finish this piece… we got the permission to go on [with the work]…" (Participant one, page four, paragraph 31)

In other cases, if young people were deemed to have made enough progress they were discharged from the service.

> "…a lot of those who are coming to 17 will be discharged anyway so we're talking about a small number!" (Participant five, page 35, paragraph 151).

Lastly, if the young person was deemed to be in need of long term on-going support, then a decision was made to refer to AMHs. Below are illustrations of needing long term on-going support.

> "…well it might be about doing a formulation as to how far they have come and where they are currently…whether they need further on-going support that CAMHs obviously can't provide…" (Participant seven, page 17, paragraph 82)

> "…she just wasn't well enough and the family support wasn't robust enough for her to manage without services and she couldn't continue to be involved with CAMHS longer term…" (Participants three, page 16, paragraph 86)

> "…it was quite clear she was going to need transition…" (Participant three, page 3, paragraph 10)

5.3.1.3 Continuity of care

As I explored the property identifying the needs, I identified an implicit decision making process. Part of consideration about on-going support involved the need for continuity of care. See table below for a list of the dimensions.

Table 10: Continuity of care and dimensions

Property	Dimension
Continuity of care	Continuous care Disruptions to care Delays to care

Participants spoke about the need to maintain *continuity of care,* in which case a referral would be made. Below is an illustration of participants considering continuity of care.

> "…we'd done a lot of work with this young girl and we wanted that work to continue." (Participant seven, page 26, paragraph 108)

Participants also spoke about their concerns that the transition may *disrupt the care* that young people were receiving from CAMHs.

> "…changing services will be a disruption to that flow. It doesn't mean she can't carry on it just means it's going to be different." (Participant eight, page 66, paragraph 301)

In some circumstances professionals would delay the transition to complete a particular piece of work.

> "We were working through some of these issues and it was kind of a crucial time for her [in the therapy]…." (Participant one, page 3, paragraph 28)

> "first of all…for me…..as a therapist….the difficulty would be basically just kind of letting her go where she was at that point in therapy... Because of where she was in therapy and we felt that we just needed probably another 3 or 4 months to finish this piece of work and basically we didn't have that 3 or 4 months because of the time or the age that she was, and then thankfully we kind of got the permission and we went on (Participant one, page 4, paragraph 31)

Lastly, participants spoke about how once a referral had been made and accepted by AMHs, it was highly likely that young people would be placed on a waiting list for AMHs.

> "There was a massive waiting list for adult mental health." (Participant one, page one, paragraph 12)

> "(in response to being questioned about access to AMHs services)…well you have got easy access but you have to wait for it because of the demand" (Participant five, page 29, paragraph 112)

Being placed on a waiting list was deemed to be a *delay to the care* that young people received. When this occurred, participants described how they continued to work with young people until they are seen in AMHs.

> "she said that she will be seeing me till I get transferred to adult services" (Participant six, page 8, paragraph 62)

> "…whilst your facilitating [the transition] be mindful of what you are doing with the young person and keep that [therapeutic] work going" (Participant five, page 23, paragraph 85)

Although the property continuity of care did not directly influence the decision of whether or not a referral was made, it did form part of their thinking about the transition process and it guided decisions about the transition plan at a later date. In addition, when the transition took longer than had been expected, it increased the anxiety of professionals.

5.3.1.4 Identifying the diagnosis

Similar to age, diagnosis of the young person acted as another criterion for determining eligibility for entry into AMHs. The dimensions are listed in the table below.

Table 11: Identifying the diagnosis and dimensions

Property	Dimension
Identifying the diagnosis	Clear Vague

When participants made reference to diagnosis being vague, they were not referring to a specific diagnosis (although three of the participants named Autistic Spectrum disorder and ADHD as vague diagnoses). Instead, they were referring to how diagnosis was evidence that the young person met criteria for AMHs. Below is an illustration of a vague diagnosis.

> "One of the things that other people have spoken about is when things are not clear, so when things [referring to the diagnosis] are a little bit vague, and people are unsure whether the young person will meet adult criteria…" (Participant five, page 39, paragraph 174)

> "…as I said earlier the ones where there more vague say like….things like ADHD and ASC [Autistic Spectrum Condition] are certainly harder transitions between CAMHS and adult services…" (Participant three, page 12, paragraph 68)

The context within which the word *clear* was used appeared to be referring to how obvious it was that the young person met criteria. In such cases, the transition was described as smooth.

> "…transitions are much smoother when there are a clear cut…concrete diagnosis. That is evident that it would meet criteria for both services" (Participant three, page 2, paragraph 8)

5.3.1.5 Considering risk

This property is about the risk of harm to self or others; this included physical harm and other factors such as risk of becoming socially isolated that may disadvantage young people in later life. The dimensions have been listed in Table 12. Below are illustrations of where participants spoke about risk.

> "…well basically because of her level of self-harm…… the fact that she was self-harming" (Participant one, page 3, paragraph 26)

> "..in terms of risk, yeah, malnutrition and starvation is quite serous with people with eating disorders. If we think about statistically, eating disorders carry the highest death rate because of the physical complications and implications of starvation and not eating properly. So there are huge risk factors." (Participant seven, page 6, paragraph 25)

Table 12: Considering risk and dimensions

Property	Dimensions
Considering risk	High risk Low risk

I interpreted the dimensions of risk as *high risk* and *low risk*. The level of risk seemed to be determined by the level of impact. This is illustrated in the example above, where the participant spoke about a higher mortality rate amongst those with an eating disorder. This would be the most extreme case of risk, and so I interpreted this as being high risk. Whereas other risks such as self-harm via cutting were considered to be of lower risk.

At this stage of the transition, consideration of risk identified the needs of the young person. Incidents of high risk were seen as an indicator of on-going needs, which determined the necessity of input by mental health services. In which case, professionals were more inclined to make the referral to AMHs.

> "Researcher – So just summarising…the things you considered when making the decision to make the referral were medication, risk issues, on-going / unmet need.
>
> Participant – Yeah." (Participant seven, 6, paragraph, 26 and 27)

5.3.1.6 Meeting criteria

This property relates to the cumulative influence of age, diagnosis, risk and continuity of care. These properties were interpreted as forming the structure of the decision-making process. So for instance, if a young person is at or nearing adult age (i.e. the age boundary), with a clear diagnosis and some level of risk, it was likely that a referral would be made. Taking these factors into account seemed to offer professionals some level of confidence that the young person met AMHs criteria. On the other hand, when the diagnosis was vague and there was no identifiable risk, CAMHs professionals are

more likely to predict that a referral would either be rejected by AMHs or there would be difficulties with the transition process.

Table 13: Meeting criteria and dimensions

Property	Dimension
Meeting criteria	Meets criteria Not meeting criteria Unclear

This then led me to infer that there were three dimensions to this property; *meets criteria, not meeting criteria* and *unclear*. It seems that when there was uncertainty about the transition it left stakeholders feeling anxious, as illustrated below. This is related to the sub-category, containing anxiety (section number).

> "One of the things that other people have spoken about is when things are not clear, so when things are a little bit vague, and people are unsure whether the young person will meet adult criteria, anxiety levels tend to rise" (Participant five, page 39, paragraph 174)

5.3.2 Identifying the gap

Upon identifying eligibility, there were three possible outcomes, 1) the young person did not need any more support and was discharged; 2), it was clear that the young person needed on-going support and met criteria, in which case a referral was made; 3) they required on-going support but it was questionable whether they met criteria for AMHs. Based on the transcribed data, of those young people who fell into the latter category, there was a fraction that did not make the transition, by exploring this group I was able identify a gap in service provision. The properties of this sub-category have been identified as: *Factors creating the gap, Outcome of the referral* and *Filling in the gap.*

5.3.2.1 Factors creating the gap

From the analysis two factors appeared to lead to a gap between the services; *age* and *diagnosis.* These formed the dimensions of the property, see table below.

Table 14: Factors creating the gap and dimensions

Property	Dimensions
Factors creating the gap	Age Criteria

Participant stated the maximum age boundary for CAMHs was identified as 17, whilst the minimum age for AMHs was 18. As a result, there existed a gap between the services, and those who fell between the ages of 17 and 18 technically, were not eligible for either service.

> "...you've got to wait till they're 18….but we finish at 17….what do we do….." (Participant two, page 17, paragraph 121)

Participants also noted that some diagnoses or difficulties met criteria for CAMHs but did not meet the threshold for AMHs.

> "…he was assessed and it was found that whilst he was on the spectrum he wasn't far enough on the spectrum…So he didn't actually get transferred over to adult mental health but it was clear that he had a challenge." (Participant two, page 6, paragraph 33)

> "…there's maybe a vagueness about whether it meets adult criteria but it would still meet CAMHS criteria." (Participant three, page 2, paragraph 8)

5.3.2.2 Outcome of the referral

The property explains the outcome of the referral, there were two dimensions whereby AMHs either *accept the referral* or *reject the referral* (see Table 16, below).

Table 15: Outcome of the referral and dimensions

Property	Dimensions
Outcome of the referral	Accepting the referral Rejecting the referral

Below are examples of the dimensions.

> "The adult eating disorder nurse in that meeting said 'she does not meet my criteria I will not be working with this girl!'" (Participants seven, page 25, paragraph 104)

> "…treated straight away from adult services because he was quite clearly going to be transferred over and it would make sense that we would start from the beginning. And that worked really well for the family and the young person. (Participant three, page 6, paragraph 26)

5.3.2.3 Filling in the gap

Participants from CAMHs spoke about the dilemma they faced when young people who were in need of support but were rejected by AMHs. In such cases, participants often resolved the dilemma by continuing the work with the young person despite the fact they had passed the age boundary.

> "So then we would end up keeping them because then in order for them to remain within the system so as to once they turn 18 access services." (Participant two, page, 7, paragraph 37)

This property was based on the extract of one of the participants and has not been saturated. However, it seemed to have significance, as it highlighted a dilemma implicit in the process that will be discussed in Chapter Six (General discussion).

5.3.3 Initiating the transition

As the title suggests, this sub-category marks the start of the transition process. There are three properties to this sub-category, see table below.

Table 16: Initiating the transition and properties

Sub-category	Properties
Initiating the transition	Making the referral Seeking consent Wearing different hats

5.3.3.1 Making the referral

This property defined the two main methods by which professionals in CAMHs make the referral. The dimensions are listed in Table 17.

Table 17: Making the referral and dimensions

Property	Dimension
Making the referral	Face-to-face Writing a referral letter

Participants described how the method chosen to make the referral influenced the transition process. They spoke about how face-to-face discussions were better and supported the transition as opposed to writing a referral letter on its own. According to CAMHs participants, it allowed professionals in AMHs to relate and identify with the service user.

> "I think there is a big difference between having a face-to-face discussion with a clinician. [It highlights that] I'm working with an individual versus I've received a referral letter…" (Participant three, paragraph 22).

> "Then we would generally write a referral letter to adult services and wait for a response (laughs) which roughly takes about three months…yeah….it's a very very slow process." (Participant seven, page 17, paragraph 8)

5.3.3.2 Seeking consent

In order to make the referral, CAMHs spoke about seeking consent of young people and families. This sub-category highlights the complication that can arise at this point. The dimensions of this category have been provided in the table below.

Table 18: Seeking consent and dimensions

Property	Dimension
Seeking consent	Refusing to give consent Gaining consent Expressing ambivalence

The dimensions identify the range of responses that professionals receive from service users and families. Below are illustrations of the first two dimensions; *refusing to give consent*, and *gaining consent*.

> "…it's also about the attitude of the young person and the attitude of the family. They are not in agreement with the transition plan and so what do you do. This young person refuses to move on." (Participant two, page 13, paragraph 95)

> "I let the family know what I will be liaising with Adult services. So you get their consent first…" (Participants three, page 14, paragraph 82)

The third dimension *expressing ambivalence* was inferred from the data, below is an illustration of a young person expressing ambivalence. The extract is from an interview with a CAMHs professional.

> "Yeah! I think in the end that decision was taken out of my hands because of her taking an overdose actually. So yeah. I think that might have re-assured me that hang on a minute despite her saying no no no….she does still need support. I think she was able to see that herself a little bit after and maybe she wasn't dealing with things as well as she would have hoped to have done" (Participant seven, page 55, paragraph, 256)

During the interview with a young person, she appeared to express conflicting feelings. She had previously informed the professional that she did not want any further support from services, and believed she was well enough to be discharged. However, there was

an increase in self-harm resulting in admission to A & E; the participant explained how she saw this as evidence in support of her decision. I interpreted this contradiction as a form of expressing ambivalence. Expressing ambivalence appeared to be related to *Imposing support*, which is a property of *Points of conflict* and will be discussed later.

In order to agree and facilitate the transitional plan there was a need for services to work together, this was where a lot of the conflicts seemed to emerge, as there were significant differences stemming from the underpinning culture within each service. Therefore in order to explain how conflicts arose I will first discuss the differences between the two services.

5.3.4 Differences between services

Services were differentiated in terms of shared beliefs, values, practices and expectations. The properties of this sub-category identify the differences, and have been listed in the table below.

Table 19: Differences between services and properties

Sub-category	Property
Differences between services	Differences in culture Assumptions about competence and responsibility Perceived differences in working practices Perceived differences levels of support

5.3.4.1 Differences in culture

The culture for each service was elicited by highlighting the shared beliefs and assumptions about the service users. I considered these shared beliefs to be the basis of the culture within the service. The dimensions for this property are listed in Table 21.

Table 20: Differences in culture and dimensions

Property	Dimension
Differences in culture	Child in the context of the family Autonomous individual

The extract below is taken from one of the transcripts as evidence of the cultural difference.

> "…because the two services are very different…..they're….in terms of service they're culturally different in the way they work…" (Participant five, page 10, paragraph 38)

> "…we do have a completely different way I suppose, maybe supporting a young person, not just in transition but in terms of therapy and the level of support they need. You know we do treat them like young people and maybe not as much as like adults so they have to make decisions." (Participant seven, page 8, paragraph 33)

CAMHs work in the belief that the service user is a *child in the context of the family*. The label was an in vivo code; it was a statement commonly used amongst CAMHs clinicians throughout the interviews. Below is an extract evidencing the dimension.

> "CAMHs work in the sense of [viewing] the child in the context of the family. When you move to adult services you are an adult" (Participant five, page 3, paragraph 10)

Implicit in this statement, is the belief that the young person is not considered an adult by CAMHs clinicians. However, when the young person enters AMHs, they are seen as an adult. The differing belief about the service user led to differing expectations.

> "So they probably treated her as somebody who was very much 18 plus but from our point of view we still see that person whose going into adult as maybe as a young person." (Participant seven, page 9, paragraph 37)

> "Expectations are very different…we're very much about helping them to mature, by the time they get into adult mental health there is an expectation on capacity to function [as an adult]…" (Participant one, page 12, paragraph 85)

On the other hand, the underpinning belief within AMHs was that the service user was an autonomous individual. Consequently, I interpreted AMHs professionals as viewing the service user as an adult, and they expected the young person to act accordingly.

> "When you move to adult services you are an adult…it's you…it's not the context of your family, they require you have, you know more personal responsibility for your health." (Participant five, page 3, paragraph 10)

The expectation of AMHs and CAMHs professionals were interpreted as being implicitly linked to assumptions about adulthood, childhood and emerging adulthood, how these assumptions influence the experience of the transition will be discussed in the category Changing status.

5.3.4.2 Assumptions about competence and responsibility

This property is closely linked with the category 'changing status' and discusses how perceptions about adulthood influence the level of responsibility that young people are expected to take on. In the context of this study, responsibility related to the authority and responsibility for decisions. The dimensions of this property relate to the how responsibility was shared amongst stakeholders.

Table 21: Differences in responsibility and dimensions

Property	Dimensions
Assumptions about competence and responsibility	Triadic relationship of responsibility Dyadic relationship of responsibility

Below are illustrations of the dimensions.

"…it will be slightly different, you will be deemed in the eyes of the service as an adult; which requires that you have, you know, more personal responsibility for your health, what you're doing and what you're not doing." (Participant five, page 14, paragraph 48)

"…in CAMHs the responsibility lies with the parents and to an extent the therapist and the young person, especially if they are under 16; whereas with adult mental health the responsibility of therapy is entirely their [i.e. the young person] responsibility." (Participant one, page 5, paragraph 39)

"…whereas in the adult sides, it's very much left to the individual whether they take the responsibility [for their treatment]…" (Participant four, page, 2, paragraph 14)

5.3.4.3 Perceived differences in working practices

The underlying beliefs influenced the way in which clinicians engaged with their respective client groups. The dimensions for this property identified that CAMHs worked with a *systemic approach* whilst AMHs work with an *individualistic approach* (see table below).

Table 22: Perceived differences in working practices and dimensions

Property	Dimensions
Perceived differences in working practices	Systemic approach Individualistic

Below is an extract evidencing that CAMHs adopted a systemic approach to working with service users.

"…we have a holistic systemic approach…" (Participant two, page12, paragraph 89)

"…and yet I'm not a systemic therapist, if that makes sense, so I'm not trained as a systemic therapist but yeah probably my mind set is such that you do work in that way." (Participant three, page 11, paragraph 56)

With emphasis placed on the developmental status and dynamics in the family, CAMHs workers would often involve families in treatment and or decisions.

> "…in CAMHs it is slightly different because we're not looking at the young person, we assist the family and we're talking to the family members as well…its different in AMHs" (Participant five, page 14, paragraph 50)

> "we go into the family we work with mum, we work with the younger siblings. We meet with the wider family." (Participant two, page 4, paragraph 23)

Additionally, they also offered interventions that were geared towards supporting families, i.e. family therapy. Involving families was considered to be evidence of the systemic approach.

> "But I don't think in adult services they can access the things so readily that they can access in camhs. For example they can't access psychology packages; they can't access psychotherapy, family therapy, speech and language. I don't think those things are so easily accessible because for camhs it's all under one roof (Participant five, page 28, paragraph 111)

Adopting a systemic approach also meant that CAMHs clinicians would work closely with external agencies, e.g. education services and the youth justice system.

> "….I supported her through her transition into higher education…" (Participant two, page 2, paragraph 13)

> "…also liaison with other agencies because she was still in education but was struggling to manage mainstream education. So we helped her access out of mainstream education support through our student support service. We also offered them [educational provision] advice and support on how to manage her symptomology whilst she was in and educational setting" (Participant three, page 2, paragraph 10)

> "we will work really really hard with that young person, liaising with schools and liaising with colleges, setting up meetings and being that young person's second voice if they need it" (Participant seven, page 47, paragraph 204)

> "…the model that you're working with the child and the families, there's liaison with social care and various things. You know youth offending [teams]…" (Participant five, page 14, paragraph 50)

When participants spoke about AMHs working practices, they emphasised that AMHs worked solely with the individual and did not involve parents. Therefore, based on their descriptions I interpreted AMHs approach as being individualistic.

> "I think by definition being in adult services you are dealing with the identified person…" (Participant five, page 13, paragraph 46)

> "…the focus is very much about them and how they think and how they feel." (Participant four, page 10, paragraph 65)

"When you move to adult services you are an adult…it's you…" (Participant five, page 3, paragraph 46)

5.3.4.4 Perceived differences in level of support

Through the analysis participants reported a difference in the level of support. However upon exploring this it seemed to be more about their perception based on the differences in working practices as opposed to an actual difference. I decided to include this as a property because this view was also shared by all participants, so it was deemed to have some significance to the experience. The dimensions of this property are detailed in the table below.

Table 23: Perceived differences in level of support and dimensions

Property	Dimension
Perceived differences in level of support	Intensive support Less intensive support

There was a common consensus that service users received [more] intensive support from CAMHs in comparison to support offered in AMHs. Professional's judgments about level of intensity appeared to be based on factors such as the frequency of appointments and having multiple professionals involved in providing treatment. Participants also made judgements based on the service provision and how service users in CAMHs have access to interventions that cannot be accessed in AMHs e.g. family therapy.

"I don't think they offer as much in terms of support…Whereas I think in adult services although they may have some of the same, or similar resources they don't have all of them. So for example I know that adult services don't have family therapy" (Participant seven, page 10, paragraphs 41 and 43)

"They have got an allocated worker who they see every two or three weeks…..whereas in CAMHs it can be a little more intense..." (Participant five, page 3, paragraph 10)

The perception that AMHs offer less intensive support was also shared by parents and young people and exacerbated feelings of anxiety.

> "So we had a very gradual, staged reduction because actually she was very nervous about losing the intensive support she had had at CAMHS…." (Participant three, page 3, paragraph 10)

> "…both for myself and our team and the mother and the young person…all fear that support will alter" (Participant two, page 11, paragraph 77)

> "I think parents and young people worry that once they leave our service they're not going to get that in Adult services [referring the level of support] " (Participant seven, page 47, paragraph 204)

Other factors discussed, but with less significance were differences in processes, language and documentation. There was no evidence in the data to suggest that this property could create any significant conflicts. However, participants spoke about the inconsistencies this creates when moving from CAMHs to AMHs and so a decision was made to include this into the final theory. In the illustration below, of how having different documentation can lead to confusion.

> "…it didn't take me long to realise that actually that form was there just in a different way. It was in letter format ….and so I think it's very small things like that , that are very easily resolved once you realise…" (Participant three, page 13, paragraph 74)

5.3.5 Points of conflict

In the context of this study, conflicts were defined as a point where stakeholders encountered difficulties or barriers to the transition. Points of conflict were considered to be closely linked to all sub-categories that have been presented thus far. There was potential for conflicts to arise at any given point throughout the transition; although it appeared that a majority of them stemmed from the differences between the two services. See table below for the list of dimensions.

Table 24: Points of conflict and properties

Sub-category	Properties
Points of conflict	Service level conflicts Communication Imposing support

Some conflicts impacted on the success of the transition but also had a bearing on how the transition was experienced; the latter will be discussed in category; Reflections on the process (Section 5.6). Each property relates to a type of conflict, and describes how and why conflicts arose. The properties were identified as *service level conflicts, communication, imposing support.*

5.3.5.1 Service level conflicts

This property relates to the various types of difficulties that arose due to the structure of services. The dimensions of this property have been listed below. Due to level of detail required for each of these dimensions, I will present each individually.

Table 25: Service level conflicts and dimensions

Property	Dimensions
Service level conflicts	Conflicting cultures Differing views about responsibility Conflictual working practices Having a vague diagnosis Differing perspectives of need Being on a waiting list

5.3.5.1.1 Conflicting cultures

In the previous section, I discussed the differences between the two services. What became apparent was that a cultural tension existed between services and they each held conflicting views about the service user. AMHs assumed the service user was an adult, able to take on full responsibility and authority to make decisions. This belief led AMHs professionals to expect the young person to be responsible, independent and make autonomous decisions about their care and treatment. This is illustrated in the extract below which highlights the expectations that AMHs held about service users.

> "…the adult eating disorder nurse stressed quite clearly to the young person we are an adult team we do not hold your hand like camhs do…" (Participant seven, page 8, paragraph 33)

This however conflicted with the views of CAMHs professionals and in some cases it led to disagreements between professionals, as illustrated in the extract below from a CAMHs participant. The participant explained earlier in the interview how a conflict had arisen because the AMHs professional had been discussing independent living as part of the transitional plan, she did not think this was appropriate. She ended this discussion with the extract below; stating that she did not feel the chronological age dictated the developmental stage that the young person was at. The second extract supports the view held by CAMHs professionals that young people do not always function as adults.

> "…just because she's suddenly turned 17 doesn't make you an adult that understands all adult language and all adult interventions and you should suddenly be independent" (Participant three, page 4, paragraph 18)

> "…we go up to 17….a lot of young people we see they're not functioning like adults emotionally" (Participant five, page 24, paragraph 93)

This view was shared by the parent, who when asked about any concerns and thoughts about the transition she responded with the following statement.

> "…she seems so young to be in adult services and I consider her to be quite mature, she's quite grown up, she's thoughtful and she's sensible (long pause)

> but I would never dream of calling her an adult yet. I don't think she's an adult." (Participant eight, page 11, paragraph 58)

Due to the fact that each service views the young person as being at different developmental stages means they vary in terms of their expectations and assumptions about the service user. This can create disagreements or conflicts between stakeholders. However, each service is geared towards their respective client group, so moving from CAMHs to AMHs means young people having to adjust to different expectations. Adjustment and the transition into adulthood will be discussed in more detail in the category changing status (Section 5.5). I have provided these extracts for illustration purposes.

5.3.5.1.2 Differing views about responsibility

As young people move from CAMHs to AMHs, they move from being in a triadic relationship of responsibility to a dyadic one. This had two consequences which created conflicts; firstly there was an assumption that service users were ready to take on the responsibility and authority to make decisions. The data seemed to suggest that this was not the case, and the prospect of having to do so was anxiety provoking for some young people.

> "When you move to adults services, you [referring to the young person] are not seen in the context of the family and I think that can be a little bit of a shock and a struggle for young people and indeed their families" (Participant five, page 3, paragraph 10)

> "It varies…we have had some who are very anxious and haven't quite liked it because they've been very used to the adults talking about them and for them." (Participant four, page 3, paragraph 18)

Secondly, the transition also resulted in parents having to relinquish their responsibility and authority to make decisions.

> "First of all, once they get into adult service they can discharge themselves. There's kind of like, nothing to say they have to stay in that service, and I'm not saying that's the way it should be or shouldn't be, its generally the parents that have that control really and make the decision about whether the young person

> will continue with support from CAMHs" (Participant seven, page 10, paragraph 41)

This highlights a change in roles, relationships and a period of adjustment for the service users and families, which will be further discussed in the next two categories.

5.3.5.1.3 Conflictual working practices

The transition results in parents not being involved in treatment or decisions post transition, due to the different working practices. This can be difficult and anxiety provoking for parents/ young people. Participants spoke about how this can lead to conflicts between stakeholders, as illustrated in the examples below.

> "…parents are very involved with what's going on and what they [referring to the young person] need to be doing…. Whereas in the adult sides, it's very much left to that individual whether they take the responsibility to do it……we have had discussions with parents…and sometimes they haven't been pleasant ones" (Participant four, page 2, paragraph 14-16)

> "…the care co-ordinator had said that you won't be allowed in that assessment…the mother was adamant…I informed the mother that it would just be the daughter that I am talking to and if she needed we night involve her but chances were that I wont really need to in the session, and the mother got angry." (Participant four, page 17, p114)

Below is another illustration, the CAMHs participant is explaining why the transition of an 18 year old service user currently on an in-patients ward would be discharged back to CAMHs, despite the fact that she had passed the age boundary. In the extract, he explains this was because the mother of the service user disagreed with the care package being offered by AMHs as it differed from what she had previously received in CAMHs. In the context of this study, this disagreement was considered to be a point of conflict.

> "the young person's mum isn't happy at the moment with what adult services are offering….because see they said yes you will have an identified worker but you will see the consultant every 3 or 4 months. It's a different set-up and I think for parents or carers its actually understanding why that might be." (Participant five, page 17, paragraph 59)

The above quote also highlights the power and authority that parents have in the care of their child, which will be discussed further in the category, Changing status.

5.3.5.1.4 Having a vague diagnosis

Participants spoke about how diagnosis played a crucial role in ascertaining whether the young person met criteria for AMHs, some diagnoses/ difficulties led to eligibility for CAMHs but not for AMHs. While a vague diagnosis did not automatically disqualify service users from accessing support, it was deemed to be a point in the transition where conflict could potentially arise; as having a vague diagnosis left professionals in doubt about eligibility and CAMHs professionals then have to justify their decision to refer to AMHs. If AMHs did not agree, then it led to conflicts. The quotations below are examples of this.

> "…his transition has been a nightmare….its …again if the label [referring to the diagnosis] isn't clearly identified it's hard to move them on." (Participant two, page 13, paragraph 95)

> "Where I think, where transition's become…less consistent is where there's maybe vagueness about whether it meets adult criteria but it would still meet CAMHS criteria. So there's a role for some sort of level of support, whether it needs secondary care mental health in adults?….erm…it can be trickier." (Participant three, page 2, paragraph 8)

> "I often find it challenging some of the labels that they give them and how ineffective some of these labels can actually be for both the young person and the service. It doesn't help you to move them on" (Participant two, page 6, paragraph 37)

5.3.5.1.5 Differing perspectives on level of need

Participants spoke of disagreements between CAMHs and AMHs about the level of need. Below is an illustration of the disagreements between CAMHs and AMHs.

> "Other cases that I've worked with where they've been assessed by adult services and adult services have come back and said that the person does not suffer with or does not have the enduring challenges that you say they have..." (Participant two, page 6, paragraph 35)

The risk of the transition being disrupted was elevated when professionals disagreed about the level of need. In the extract above, the participant went on to inform me that the referral had been rejected. Therefore it can be inferred that when there is a marked difference in perspectives on need, there was a raised probability that the transition will not occur. Below is an example illustrating that although the young person had been rejected by one AMHs team, she had been accepted by another. So in this instance the transition went ahead despite the differences.

> "There were disagreements about maybe this girl going into adult services…that would have needed that support…The eating disorder nurse in that meeting said 'she doesn't meet my criteria I will not be working with this girl….the adult consultant psychiatrist made an appointment to see this girl in outpatients" (Participant seven, page 25, paragraph 104)

However, what seemed to make the difference was how these disagreements were resolved. How participants were able to navigate such difficulties/ conflicts will be discussed in the section titled (*Ironing out the differences)*. Lastly, it is worth noting here that based on the extract above there seemed to be different criteria among AMHs teams, however this was not raised in other interviews, and this was the sole reference to this point. Unfortunately due to time constraints and difficulties with recruitment I was unable to explore this further, but I felt it was significant enough to briefly mention this here.

5.3.5.1.6 Being on a waiting list

In the earlier section (Continuity of care) participants described how being on a waiting list had a bearing on the continuity of care that service users received. When placed on a waiting list for AMHs, CAMHs clinicians expressed concerns for the impact this may have on the mental health of the young person. To ensure continuity, in most cases, CAMHs professionals continued to work with young people until they received their first appointment with AMHs. For CAMHs clinicians, however, having young people

placed on a waiting list as they transitioned created a conflict between their duty of care to the service user and their responsibilities to the service and commissioners, see extract below.

> "…I just wanted to make sure things were in place for this girl, I mean by this time this girl was over 18 and in terms of commissioning we don't actually get paid for this." (Participant seven, page 40, paragraph 170)

Intrapersonal conflicts also arose for CAMHs clinicians when they received referrals for young people who were nearing the age boundary, as again they will be placed on a waiting list but within CAMHs. In such cases, it is highly likely that the young person will pass the maximum age boundary for CAMHs.

> "…they might not be seen till they're 16 and 11 months or 16 and 10 months. So then if you see them at choice and they need something else, then there's always this dilemma bout erm…..well….they're in our service we have a duty of care what do we do" (Participant five, page 7, paragraph 22)

The above quotation is another example of how CAMHs professionals are faced with having to make a decision about whether to prioritise the client's needs even though they are not commissioned to do so. Additionally, is it in the best interest of the young person to commence treatment when it is likely they will pass the age boundary and most likely require transition to AMHs. How these dilemmas are addressed will be covered in more detail in the category ironing out the differences.

5.3.5.2 Communication

Communication related to the exchange of information between stakeholders. Communication between all stakeholders was deemed to play a key role in how the transition was experienced. The dimensions have been listed in Table 26. Below are some extracts where participants stressed the importance of communication.

> "…and I think communication is the biggest thing that is between staff, between different professionals, with the client and any new professionals that are also involved as well." (Participant four, page 13, paragraph 91)

> "I think, it's become a bit of a cliché I suppose….but communication is, you know, it's vital". (Participant eight, page 55, paragraph 253)

This property has been divided into three dimensions; *clear communication, poor communication* and *lost in translation.* Each dimension relates to the conditions under which communication can influence the transition, the latter two dimensions are when conflicts tend to arise.

Table 26: Communication and dimensions

Property	Dimensions
Communication	Clear communication Poor communication Lost in translation

Where there was clear communication, participants could be sure about what they can and cannot expect. The extract below, is an example of where communication has been clear. Although the participant was actually referring to how AMHs were deemed to be too rigid. Implicit in this statement is the fact AMHs had been very clear about their age boundary and so he was able to predict how AMHs would react.

> "They're very clear, they're very boundaried around their age range. So they won't do that…" (Participant five, page 6, paragraph 22)

Being clear in communication eliminated uncertainty, participants explained how clear communication gave stakeholders a certain level of confidence about what to expect. Being clear and knowing what to expect are related to the sub-category *containing anxiety*, as knowing what to expect led to the least amount of anxiety and conflict. As illustrated in the extract from a parent in response to being kept informed about the transition.

> "I think the more you know, the more comfortable you feel with something, you know." (Participant eight, page 21, paragraph 108)

I interpreted poor communication as the overarching title that encapsulated any incident of misunderstandings, misinterpretations, lack of clarity and lack of contact. In short, any instance in the data where there was either a break or disruption in communication was seen as poor communication.

Participants described how a lack of communication led to conflicts. Below are extracts from the transcript evidencing this.

> "…what I've found difficult is a lack of communication." (Participant two, page 25, paragraph 26)

> "But the community recovery service, we heard nothing from them!.." (Participant seven, page 25, paragraph 104).

Another example of poor communication was when stakeholders were not explicit when discussing the transition process. This often led to misunderstanding and uncertainty (as there was a lack of clarity) and in some cases the uncertainty bred anxiety. Below is an extract in which I had summarised a participants' response to the importance of communication, the participant had confirmed it was an accurate description.

> "One of the things that other people have spoken about is when things are not clear, so when things are a little bit vague, and people are unsure whether the young person will meet adult criteria, anxiety levels are raised" (Participant five, page 39, 174)

The extracts below are examples of where the consequence of how not being clear had left the young person and families feeling anxious, which then created conflicts between stakeholders. In the first example the participant reported AMHs had been discussing independent living with the young person as part of the transition process. During these conversations the AMHs clinician had not been clear about a timeframe, and hence the young person had assumed they would be expected to move into independent living in the very near future. This had created conflict between the parents/ young person and the AMH clinician, the participant spoke about having to intervene at this point. The latter extract is an example of how a lack of communication from AMHs, meant that he

was unable to provide an update about the transition. He describes how this lead to uncertainty and anxiety.

> "So I guess part of that communication was about helping them see that when you're talking about it they're (i.e. parent and young person) fear is that you will be doing that at 17 so I guess some of the things I did differently was helping them understand those kind of dilemmas and see how they needed to be quite clear with their communication with this young person" (Participant three, page 5, paragraph 18)

> "…and your saying well actually we've contacted the service and we're just waiting for a reply and I'll chase them up…it can cause uncertainty and anxiety in some people" (Participant five, page 38, paragraph 139)

Other examples of poor communication related to how the same words used in both services were sometimes used to mean different things, this is illustrated in the extract below.

> "…in some respects I think they might think they are using the same language but not necessarily." (Participant three, page 13, paragraph 74)

When this occurs, language can become a barrier to the transition process.

> "…so I think what happens then people get caught up in the language rather than the needs." (Participant three, page 13, paragraph 13)

Here she is referring to how AMHs use the CPA approach, which stands for Care plan approach. This is a working document used to record care-packages for service users. She talked about how when she left AMHs and began to work in CAMHs, she noted there was a difference in language and documentation. She spoke about how these factors created language barriers throughout the transition process.

> "…understanding each other's language appears to be a recurring theme and very often adult colleagues will contact me [and say] can I just run this by you because it seems I'm trying to discuss something with one of your colleagues and I'm….we're hitting a language barrier" (Participant three, page 13, paragraph 72)

Other examples of differences in meaning also included the words used by participants to describe the service user. Participants either used the words, *clients* or *patients* but then also used the terms *children, adults* or *young people* as well. In each case, they are

all referring to the service user; however the meaning, connotations, expectations and assumptions for each word vary significantly, as detailed in the sub-category differences between services. Below are a few examples of the various terms used to describe young people.

> "…Was using the term patient …" (Participant one, page 12, paragraph 105)
>
> "…some of our clients…" (Participant two, page 17, paragraph 125)
>
> "…children who are just turning 17…" (Participant four, page 1, paragraph 8)
>
> "…tailored for younger adults…" (Participant eight, page 22, paragraph 116)

5.3.5.3 Imposing support

When a young person refuses to make the transition or is ambivalent about it, but are in definite need of on-going support, professionals will insist that the transition into adult mental health goes ahead despite the lack of consent. Based on the analysis of the young person's interview I interpreted this as *imposing support*. The dimensions for this property were defined as *refusing to transition* and *refusing to discharge without support*. The former is related to the young people and parent, whilst the latter is related to the service.

Table 27: Imposing support and dimensions

Property	Dimension
Imposing support	Refusing to transition Refusing to discharge without support Not having capacity

What is highlighted here is a difference of opinion, which was seen as leading to disagreements between stakeholders. Depending on how this situation was managed determined the extent to which it disrupted the transition. Below are several examples

of imposing support. The first extract is from a young person stating that she did not want further support, this is an example of *refusing to transition*. However, she reported feeling like she did not have a choice about making the transition, as she was told she could not attend college without support. The second and third quotations are examples of when professionals had insisted the young person engage with AMHs, these are illustrations of *refusing to discharge without support*. In both cases, the analysis illuminated the underlying tensions and disagreements between service users/ parents and clinicians.

> "…because like with college as well. They erm…one of the women erm… I don't know what she does. She said that if I don't have any support then I wouldn't be able to attend the college." (Participant six, page 5, paragraph 35)
>
> "Well, I felt that I didn't have a choice and that because I know [the service] goes up to 17, that once I left here I just didn't want any more support….but I just feel that I'm being pushed to see other people…' (Participant six, page 2, paragraph 14)
>
> "So like Dr D was saying… that I needed all the support I could get… just saying that she didn't want to discharge me from here if I have no support." (Participant six, page 23, paragraph 175)
>
> "…like I say this young girl really didn't want to go to adult services and part of me feels like I kind of pushed her quite a lot to try adult services…" (Participant seven, page 54, paragraph 252)
>
> "…on point of being assessed at CAMHS was sectioned under the mental health act because he was really quite unwell…" (Participant three, page 6, paragraph 26)

In the last quote above is an example of *not having capacity*. The young person was legally deemed to be lacking capacity, in such circumstances support was imposed, however, it was at low risk of disrupting the transition. In fact, in the case that the young person lacked capacity, it appeared to facilitate the transition into adult mental health.

It was when the young person was deemed to have capacity, and either they or their parents did not agree to make the transition, that conflicts tended to arise. Below is an example of where parents and young people did not agree with the transition. This was

interpreted as a point of conflict. In the first example, the participant spoke about how the service user had refused to make the transition. What emerged was that the CAMHs clinician expressed an increased sense of responsibility following the young person's refusal. Consequently, she continued to provide support to the young person within CAMHs despite the fact that he had passed the age boundary. The second example illustrates how parents can feel displeased and disgruntled with the transition plan. The outcome in both cases was that the transition was disrupted, and continued at a later date. Therefore, in summary when young people/ parents reject or refuse to make the transition and professionals imposed support, there was a high risk that this would create conflict and thus disrupt the transition process. This also highlights issues about responsibility, decision making and power.

> "They are not necessarily in agreement with the transition plan and so what do you do. This young person refuses to move on. So you can't just walk away from it." (Participant two, page 13, paragraph 95)

> "The expectation was that adult services would go to the review and she would come out [and enter AMHS]...But that's not going to happen. She's coming back to us and the transition will continue… the young person's mum isn't happy at the moment with what adult services are offering… (Participant five, page 16-17, extracts from paragraphs 56 and 59)

5.3.6 Ironing out the differences

This sub-category relates to the range of actions and strategies that professionals adopt in order to either resolve conflicts or at the very least reduce their impact on the experience of transition; these form the properties, listed in the table below.

Table 28: Ironing out the differences and properties

Sub-category	Properties
Ironing out the differences	Accommodation Identifying role and responsibilities Creating similarities

	Joint meetings Making joint decisions Joint working Managing ethical dilemmas

5.3.6.1 Accommodation

Participants noted that when professionals from each service accommodated the other, there were often less difficulties with the transition. The properties were identified as *being flexible* and *being too rigid.*

Table 29: Accommodation and dimensions

Property	Dimensions
Accommodation	Being flexible Being too rigid

Participants described how being flexible throughout the whole transition supported and facilitated a smooth transition. There were a range of examples where professional demonstrated flexibility, in terms of criteria and service provisions. For instance, the extracts below are instances in the data where CAMHs and AMH were flexible with age criteria.

> "you know we can be flexible within a couple of weeks, but we were seeing her for a bit longer than that, just to try and finish up the piece of work we were doing" (Participant one, page3, paragraph 24)
>
> "…CAMHs are quite flexible…"
>
> "…because if you've got some children who you know, 17 year olds, who are used to having the parent in the session then we have to try and support that, but we will do it in a way that we can accommodate both child and adult services" (Participant 4, page 5, paragraph 34)

In some instances, AMHs professionals would accommodate parents depending on the needs of young person. The outcome of being flexible was that it led to a smooth transition.

> "…and actually what they would say is they [AMHs] are more likely to work with a 17 year old at transition with an eating disorder to, work more with the family as opposed to the individual" (participant three, page 12, paragraph 64)

> "it was very hard to get some of the history from him and it got to a point where I actually suggested whether it would be an idea of having one of his parents perhaps his mum come in and discuss some of the things" (participant one, page 6, paragraph 41)

In addition, AMHs would alter the length, pace and structure of sessions as a means to support adjustment to the change in services. This was seen as a strategy to also alleviate anxiety, as young people described feeling overwhelmed and anxious about attending AMHs.

> "…we've had to take into account, you know, sometimes, even lengths of sessions, when the sessions are, how frequently" (participant four, page 4, paragraph 28)

> "when they are starting here, rather than waiting in my office, I already waiting in reception for them" (Participant four, page 5, paragraph 30)

> "Well I guess that the young person's less likely to want to engage because they've had a negative experience" (Participant seven, page 33, paragraph 134)

In some situations where professionals were not accommodating, they were perceived as being too rigid.

> "I know that the adult eating disorder nurse is very…I guess this is my opinion but I guess it's something that's been shared before she can be quite strict and rigid. I think words, this is kind of like gossip and here-say, words used to describe this woman before is that she's on the spectrum. She's inflexible. (Participant seven, page 31, paragraph 136)

> "it's very very rigid as in this is the age at which they need to transition over the adult mental health…18…there is the slight flexibility as I mentioned but not massively"(Participant one, page 3, paragraph30)

5.3.6.2 Identifying roles and responsibilities

This property is linked the sub category preparing young people and families. As identifying the roles and responsibilities meant that not did it allow professionals to have a clear understanding of their roles and remit, they were also able to be clear when informing young people and families. The properties were identified as *clear roles, not knowing roles and responsibilities* and *blurred roles.*

Table 30: Identifying roles and responsibilities and dimensions

Property	Dimensions
Identifying roles and responsibilities	Clear roles Not knowing roles and responsibilities Blurred roles

Below are extracts evidencing instances of clear roles and responsibilities.

> "…from that transition meeting he had agreed that he would pick her up and he had…" (Participant seven, page 38, paragraph 166)
>
> "its really important to be able to understand peoples criteria and peoples language to then understand what will your role be in that transition and what care intervention would be required in CAMHS that helps them have a smooth transition (Participant three, page 5, paragraph20)
>
> "…we all know what everybody's role is and what it is that there all offering and delivering to the individual." (Participant four, page 7, paragraph 43)

In the extract below the young person explains how she had attended a meeting with both services present. During the meeting there were disagreements about roles, remit and whether the young person met criteria. As a result the young person was unsure about the role of each professional. Therefore when asking the young person about their understanding, they reported the following.

> "G – what have each of their roles been? Do you know?

Y – no" (Participant six, page 4, paragraph 23-24)

In the second extract the parent had not attended a joint meeting, and when asked about roles, she also stated that she did not know.

> "Researcher - So do you know what role everybody has in the transition process and what roles and responsibilities different people have?
>
> S – No not really, no I don't think I do. Not really" (Participant eight, page 21, paragraph 105-106)"

5.3.6.3 Creating similarities between services

As professionals have an awareness that young people may struggle with the differences, participants spoke about altering treatment packages to match what young people are likely to receive in AMHs. By doing so, the transition becomes a gradual process rather than a sudden change. I viewed this as supporting a smooth transition and aiding adjustment. The dimensions were identified as: *easing them in* and *feeling the difference.*

Table 31: Creating similarities between services and dimensions

Property	Dimension
Creating similarities between services	Easing them in Feeling the difference

Where professionals had been accommodating and created similarities they described that young people had been eased into the transition, whereas where this had not occurred participants reported young people felt the difference.

> "I would be starting to consider as part of my treatment plan, what….what they might be getting in adult services. So having that communication straight away so that it is not such a sudden change, I think it's really important (Participant three, page 6, paragraph 22)
>
> "I think very often what people have said is they feel the two services are very different at times and so if you can kind of help that smoothness a little bit more by kind of having similar kind of treatment and approaches erm….so that they don't feel like they are suddenly losing something or that they are suddenly gaining something that is different, but that there is some similarity between the

two services and at that stage of treatment. I think that's the most helpful steps" (Participant three, page 5, paragraph 20)

In the extract below the AMHs participant was talking about how they altered the structure of sessions to a more CAMHs orientated approach as a mean alleviate anxiety. She then went on to say that she gradually worked towards an adult-orientated way of working over a period of time.

> "So maybe how we structure the session, it doesn't feel so overwhelming for them as well. So its little things like that that we try to make it that much more relaxed but slowly do put in all those things but it's done quite tentatively." (Participant four, page 5, paragraph 30)

> "it's taken in kind of small baby steps for them" (Participant four, page 5, paragraph 30)
> "But also giving them a bit of familiarity will help them fall into therapy quite quickly and make the transition as easy as possible, emotionally for them as well." (Participant four, page 4, paragraph 28)

5.3.6.4 Joint meetings

A majority of conflicts were resolved at joint meetings. This provided a platform for all stakeholders to discuss and agree a plan for the transition. According to the analysis, the following dimensions were inferred from the data and were deemed as facilitating the transition process.

Table 32: Joint meetings and dimensions

Property	Dimensions
Joint meetings	Sharing information Understanding each other Negotiation Agreeing the plan

> "let's do a joint cpa (Care Plan Approach) meeting and you know lets meet the family and then we can talk to the family about what we could offer. So then they know what we could offer so they then know what the expectations would be. We will be clear about what their expectations are and if we can't meet them

> how we can resolve that in the interface (Participant three, page 15, [paragraph 84)

> "Then there are case conferences that we then might have to attend to kind of have that transition done from services to services. So we are aware of all the information…." (Participant four, page 1, paragraph12)

> "But what I did, what I was requested to do was go to the adult services meeting and present the case." (Participant five, page 19, paragraph 71)

Participants spoke about sharing information that is relevant to the transition process. This increased understanding of young people's needs.

> "so we are aware of the all the information and any other issues…" (Participants four, page 2, paragraph 12)

> "…we share as much information as we can..."(Participant seven, page 12, paragraph 49)

Through discussions that took place, professionals from both services developed an understanding of each other; in terms of structure, criteria and language. As mentioned earlier in the findings, it is important that professionals have a clear understanding of service structure and provision.

> "…its really important to be able to understand peoples criteria and peoples language" (Participant three, page 5, paragraph 20)

During meetings professionals addressed conflicts that arose, for instance disagreements about meeting criteria, involving parents, and the needs of young people. Conflicts were resolved through the process of negotiation, by doing so services were able to jointly develop a plan that would enable them to manoeuvre around the boundaries. This also meant that when professionals shared the plan with young people and families they are able to be clear.

> "we try and negotiate with adult services to then take over the case and transition them." (Participant five, page 5, paragraph 22)

> "I've come across obstacles where people may have a particular view about a particular family styles or approaches that can become an obstacle for treatment being offer in a certain way. Or peoples understanding as to kind of what the impact might be on family members if you weren't to have this intervention for a family. So there some of the obstacles. So professional meetings help to clear

> those without the families being part of those difficult discussions...erm…so then actually again when it gets to the point of actually meeting the family it's very clear" (Participant three, page 15, paragraph 84)

Through sharing information, understanding each other and a process of negotiation, participants were able agree on the transitional plan. These joints decision formed a common goal.

> "There's more and more of them needing to happen, it's a much easier because the professionals are already working together at the beginning to make sure that we're all singing from the same hymn sheet" (Participant four, page 7, paragraph 7)

5.3.6.5 Making joint decisions

As a result of discussions that took place during joint meetings, participants were able to arrive at a mutual agreement. This supported the transition process, as by this point professionals were able to be clear and about roles, remit, the care package and how the transition was to move forward. The dimensions were interpreted as: *mutual agreement* and *different agenda's.*

Table 33: Joint decisions and dimensions

Property	Dimension
Joint decisions	Mutual agreement Different agenda's

> "…there was a mutual agreement, and the adult team leader agreed…" (Participants seven, page 45, paragraph 198)

> "…it was a decision between two consultants, mainly shared between consultants…consultant to consultant…" (Participant three, page 7, paragraph 28)

> "…it was like a shared decision between the two services…" (Participant three, page 16, paragraph 86)

> "there was a plan at the end of that transition meeting," (Participant seven, page 39, paragraph 107)

In instances where professionals did not come to a mutual agreement, it resulted in professionals having different agendas. This created conflicts between stakeholders but also left young people and parents feeling anxious leading to a difficult transition.

> "That certainly wasn't the case, it felt as though it was a 'them against us' and it didn't feel that anything ran smoothly." (Participant seven, page 26, paragraph 108)

> "…adult services were very keen to do was to help that young person get into independent living because they perceived that as a very adult thing to do but was very scary for the young person and for the family to do…erm...and so where we had…I guess the one thing erm….that we maybe didn't do was we didn't push for that in the same way because it was very clear from the young person that although they liked the idea of that that felt very scary to comprehend." (Participant three, page 5, paragraph 18)

5.3.6.6 Joint working

Participants also emphasised the need for joint working. They gave examples of how it allowed for a smooth transition. It reduced the potential for conflicts to arise as each stakeholder was deemed to be working towards the same goals. The dimensions were considered to be *working in isolation* and *sharing the care package.*

Table 34: Joint working and dimensions

Property	Dimension
Joint working	Working in isolation Sharing the care package

Below are extracts evidencing how professionals shared the care package.

> "…with the view that we would do a shared care support package from 16 and a half" (Participant three, page 3, paragraph 10)

> "so the case conferences need to happen. There's more and more of them needing to happen, it's a much easier because the professionals are already working together at the beginning to make sure that we're all singing from the same hymn" (Participant four, page 7, paragraph 43)

Participants spoke about a lack of understanding in their particular service between CAMHs and AMHs, which often resulted in confusion. Consequently, for one participant it resulted in the perception that transitional work was difficult.

> "Not really understanding why it takes so long. Not really understanding why the cases aren't picked up more quickly through the adult services. That those are the key things for me…I think there should be a meeting between the adult's camhs and the family…bang! All in one room all sat round, this is what's going to happen…and apart from anything else it makes it more seamless for the family. They can ask all their questions to everyone and I think it promotes good working together because it feels like never the twain shall meet." (Participant five, page 33-34, paragraph 141)

5.3.6.7 Managing conflict through ethical practice

This property relates to the use of ethical codes of conduct as a tool for decision-making and management of conflicts throughout the transition process. Codes of conduct promote and maintain a standard of practice for all health professionals. Although there are various codes according to discipline, there exists similarities amongst the codes. For instances each guideline primarily emphasises the need to respect the client, promote and support self-determination and maintain boundaries, particularly in terms of the therapeutic relationship; as well as addressing issues such as consent and confidentiality. However, what transpired was the way in which the codes were applied varied according to the client group, this also accounted for some of the differences observed between services. Due to the number of dimensions, I will discuss each under a headings relating to the appropriate ethical principle.

Table 35: Managing ethical dilemmas and dimensions

Property	Dimension
Managing conflicts through ethical practice	Being boundaried Making informed decisions and consent Equality and having professional responsibility Maintaining confidentiality Best interest Autonomy of the client

5.3.6.7.1 Being boundaried

I interpreted boundaries in this context, to refer to the 'terms and conditions' of the work that was conducted by professionals; it formed the basis of establishing what is acceptable and the limits of the work from an ethical standpoint. Below are some examples of professionals establishing and maintaining boundaries. The examples below identify boundaries in terms of criteria, the therapeutic work, time-frames and involvement of parents.

> "..they're very clear, they're very boundaried around their age range" (Participant 5, pg6, para 22)
>
> "…if it's not possible and you're in the middle of something have some boundaries about how long that will be." (Participant 5, page 39, para 17)
>
> "..there's another aspect in terms ground rules for the young person and for parents." (participant 4, pg68, para 102)
>
> "…how the psychiatrist have been dealing with this individual, and what we need to learn from them or, what we need to continue or, what needs to be well boundaried with them?" (participant 4, pg7, para 41)

5.3.6.7.2 Making informed decisions and consent

Participants spoke about a difference in the way that professionals' ensured young people were making informed decisions. In camhs they tend to have more discussion about decisions to ensure informed consent. This relates to the assumptions about capacity of the young person, where capacity relates to the ability and competence of service users. In AMHs they assume capacity of the young person and so there is less discussion, as noted in the extract below. The extracts below highlight how professionals applied the codes according to the client group (in this case young people and adults).

> "It's down to a young person to decide how much they involve their family in a package of care….and we have to respect that." (Participant three, page 9, paragraph 46)

> "the young person can make an informed decision about the pros and cons to involve the family are maybe slightly different in CAMHS to in adult services" (Participant three, page 9, paragraph 46)

5.3.6.7.3 Equality and having professional responsibility

Throughout the transcripts there was evidence of professionals having to prioritise their professional responsibility to the client in spite of service pressures. Whilst young people are under the care of CAMHs, professionals have a duty of care to the service user as well as being responsible and accountable for service provision. Therefore when there are delays or disruptions to the care, CAMHs clinicians have a professional and ethical obligation to continue their role of providing care to the young person and family. This is despite the fact that the young person may have exceeded the age boundary for CAMHs. This however, creates a conflict between the ethical codes of conduct and the service criteria; this was observed to result in feelings of frustration and anxiety for CAMHs clinicians. Below are some extracts that illustrate the tension and the feelings associated with it.

> "…they're in our service we have a duty of care…" (Participant five, page 7, paragraph 22)
>
> "…where there's not a service yet there's an expectation of support. What do you do?..." (Participant two, page 7, paragraph 43)
>
> "They are not necessarily in agreement with the transition plan and so what do you do. This young person refuses to move on. So you can't just walk away from it." (Participant two, page 13, paragraph 95)
>
> "It's the most frustrating…most frustrating….you've got to wait till they're 18….but we finish at 17….what do we do…" (Participant five, page 33, paragraph 141)

This was also true for when young people enter the service late in their teens and there are strong indicators to suggest the service user is likely to need a referral to AMHs. In these circumstances, participants need to consider issues around equality, as illustrated below.

> "…ethical dilemma is that you know a young person is coming up to 17 however you can't do something different for that person because...if you like you can't discriminate against them because of their age….and that plays a part in your thinking…" (Participant five, page 8, paragraph 30)

5.3.6.7.4 Maintaining confidentiality

Application of this principle explains why AMHs do not involve parents in treatment and decisions. Due to the status of the young person and assumptions about capacity, CAMHs will involve parents. However, for AMHs, parental involvement raises an ethical dilemma; because they perceive the service user to be an adult, they are obliged to maintain confidentiality, autonomy and respect for the client. For parents, who are adjusting to the change in role, this can be perceived as them being excluded. Below are some extracts that depict this dilemma.

> "but then there's another dilemma….because you know, you have an adult and you want to bring in his parents?!" Participant 1, page 6 para 41.
>
> "you've had parents on the phone who are not happy and you've had to explain….well actually we would be breaching confidentiality of an adult if we disclosed information" participant 4, page 2, para 16.

> "She's like been there more than the other people I've seen and like other people say confidential and then they tell someone" participant 6, page 17, para 126.

> "…she didn't want her mum to go and she asked me if I could go and I took…" (Participant seven, page 20, paragraph 92)

5.3.6.7.5 Best interest

Participants spoke about working in the best interest of the client. Below are extracts as evidence of this.

> "…that would have been the best for [service user]…" (Participant one, , page 3, paragraph 30)

> "…I'm not sure that they had the young persons' best interests at heart…" (Participant seven, page 25, paragraph 108)

5.3.6.7.6 Autonomy of the client

Autonomy is a recurring concept throughout interviews; it relates to the service users level of independence. Participants, particularly from CAMHs emphasised the need to promote, facilitate and respect the autonomy of the client. This dimension is closely linked to the changing status of the young person, and I will talk about it in more detail later in the findings.

> "…to help you become an independent traveller…" (Participant two, page 8, paragraph 48)

> "So we try to make them more independent…so we say ok well try to see if we can get you to come there so that allows them to become more independent." (Participant four, page 8, paragraph 51)

5.3.7 Containing anxiety

Participants talked about transition in terms of a change in the lives of service users and families. They noted that, as with most change, the transition evokes feelings of anxiety, see below for evidence.

> "…well I think any kind of transition can be anxiety provoking or any kind of ending, or moving to a new service." (Participant five, page 39, paragraph 139)

> "…I mean families get nervous when there's areas' of change" (Participant three, page 9, paragraph 44)

Therapeutically, professionals talked about the need to contain anxiety, as anxiety can exacerbate the mental health difficulties of the service user. So far, I have presented evidence of anxiety expressed by parent's, young people and professionals. I have also given examples of how the expression of anxiety had influenced the way stakeholders engaged with the transition. For instance, parents can feel anxious about not being involved; they can be less available to support young people, resulting in the young person going into crisis. See below quote evidencing this.

> "I suppose as a parents it, it's frightening because you've been involved in the care up until now and it's like somebody saying well you're out the picture now. The focus is just on them and I don't think see as ready to be completely responsible for all of it, and I worry that it'll put her off." (Participant eight, page 17, paragraph 86)

Also, parents and young people can sometimes disagree with the transitional plan because of their anxieties, creating disruption or delays to the transition. In more extreme cases parents and young people can refuse to engage with the process. In addition, professionals also expressed anxieties about their own involvement in the process. A majority of their concerns focussed on the therapeutic progress that had been made with the young person in CAMHs and whether this will be continued in AMHs.

Therefore participants drew attention to containing anxiety as a means to limit the potential for conflicts to arise. The properties of this sub-category are: *preparing the young person/ families; level of preparedness, recognising family dynamics; wearing different hats, professional's anxiety* and *professionals seeking support.*

5.3.7.1 Preparing young people and families

Preparation was of considered to be a key factor in reducing anxiety. CAMHs participants spoke about the need to prepare young people and families for the transition. The dimensions identify the main aspects of the preparatory work; *starting*

conversations early, informing young people and families of service differences, meeting individual needs, and *having a timescale.*

Table 36: Preparing young people and families and dimensions

Property	Dimension
Preparing young people and families	Starting conversations early Informing young people and families of the service differences Meeting individual need Having a timescale

Starting conversations early allowed young people and families the time to prepare, reflect and ask questions about the transition. This dimension was inferred from the data, as although CAMHs maximum age boundary was 17, professionals typically started conversations around the age of 16 -16½.

> "Post 16 we had to…we're currently looking at a transition into adult mental health" (Participant 2, page 2, paragraph 13)

> "we might even think about it from the age of 16 ½ although we may not necessarily start that process then but we certainly would be having discussions about some of the things that we're going to have to think about in upcoming sessions because of their age." (Participant seven, page 16, paragraph 78)

> "…the preparation is discussed with the families earlier rather than later…… there's all that kind of nurturing approach, preparation and time to ask questions and reflect on all that kind of thing." (Participant five, page 29, paragraph)

Informing young people and parents about the process gave young people/ families an understanding of the change they would be embarking on. This is connected to the next property *level of preparedness*.

> "We can kind of reflect and understand with them about how different this is." (Participant four, page 9, paragraph 57)

> "I'm always very clear with them that we only go up to the age of 17 and you know…the children service stops then and they are then deemed as adults… So early on I would…I'd be talking to the young person and family about that and

> try to give them some information about what all that means really." (Participant five, page 6, paragraph 22)

> "…every session we will discuss discharge and we will discuss what discharge or transition, we'll kind of develop a plan, and what it will look like and how we can support that young person" (Participant seven, page 7, paragraph 33)

Participants also spoke about the importance of catering for individual needs. The dimension was inferred from the data (see quotes below), as participants spoke about the uniqueness of each case. My interpretation of the data, was that by tailoring the care package professionals were able to account for the individual needs of the young person thus reducing anxiety.

> "I think everyone's an individual so you try and consider what kind of interventions you use for each young person and I can think of other cases where I have transferred people with similar diagnoses but the transition and what was required, the needs were very different"(Participant three, page 4, paragraph 18)

> "…no two cases are alike…" (Participant two, page 15, paragraph 109)

> "I' don't generalise it would be very case specific. I do…. do my assessments very much as a clean slate and concentrating on what this person in front of me right now needs. (Participant one, page 10, paragraph 85)

There was another dimension to the preparatory work, which involved taking responsibility for their care and making autonomous decisions. However, being responsible and making decisions were considered to be properties of adulthood. Therefore these concepts are covered in the sub-category preparation for adulthood, in the category changing status. I mentioned them here, to show the connections between categories; as preparing someone for adulthood was inferred to reduce anxiety about the transition.

Lastly, participants spoke about having a timescale for the when the process will end, was helpful in reducing anxiety.

> "…if you're talking to families and working towards endings and transition then I think you kind of shape that up in your own mind that there's a time-scale to this. Whatever that time-scale is but it shouldn't be a long time-scale" (Participant five, page 37, paragraph 167)

Earlier in the findings, I discussed how participants were not commissioned to work with young people over the age of 17 and so sticking to agreed time-scale was an important aspect. Additionally setting a time-scale is linked with ethical practice, as it is one of the components of the terms and conditions of therapeutic work, as discussed in the earlier sub-category.

5.3.7.2 Level of preparedness

This property relates to young people and families. The level of anxiety that is experienced is connected to the level of understanding that young people and families have about the process. Having an understanding allowed young people and families to feel prepared. The degree of preparedness is influenced by the information that is given by professionals. The fundamental aim of sharing information was to ensure that young people and families were aware of what to expect as this helped to reduce anxiety levels. Therefore the dimensions of this property were identified as *knowing what to expect* and *not knowing what to expect*.

Table 37: Preparing young person/family and dimensions

Property	Dimensions
Preparing the young person/ family	Knowing what to expect Not knowing what to expect

The first extract is an example evidencing the link between knowing what to expect and anxiety levels. The second extract was taken from the interview with the young person, who reported feeling nervous and anxious about the transition but was initially unable to explain why. Later in the transcript she stated she would advise others to ask more questions as it would help them to understand what would happen. I interpreted her latter response as her having reflected on her emotions, and hence inferred that knowing what to expect can potentially reduce anxiety.

> "…but the more informed I am the more comfortable I feel about what's going to happen?" (Participant eight, page 21, paragraph 112)

> "…She was left in limbo not knowing when this transition, you know when she was going to meet the nurse and you know all this was raising her anxieties an awful lot. She just didn't know…none of us did! (Participant seven, page 44, paragraph 192)

> "I think that's the most helpful steps, so if you know what to expect or what the client will expect when they go over to adult services you can help that preparation side of things in CAMHS. So that it is not a sudden shock." (Participant three, page 5, paragraph 20)

> "Well I think one of the things that came up for me was that they… I would say the emotion that I could sort of gather from them was fear. Because they…..they're kinda of scared about what to expect and the next phase so to speak. So they weren't really sure what to expect how it would be you know. That's sort of the feeling I got from them and what was discussed in some of my sessions" (Participant one, page 13, paragraph 111)

> "Y – To ask more questions and what it's going to be about, what will happen?
> G – How would that make a difference?
> Y – because they would have more understanding about what will happen
> G – And I suppose that goes back to the thing we said in the very beginning where we said not knowing about something may make it feel quite scary.
> Y – yeah" (Participant six, page 30, paragraph 224-228)

One of the main outcomes of joint meetings was that by the end of the meeting all stakeholders knew what to expect from the process and from each other.

> "…lets do a joint CPA meeting and you know lets meet the family and then we can talk to the family about what we could offer. So they then know what we could offer and so they then know what the expectations would be" (Participant three, page 15, paragraph 84)

Based on the data, it seemed that preparation for the transition was closely linked to preparation for adulthood, and so this will be discussed in the category changing status, under the sub-category preparation for adulthood (Section 5.5.2.3).

5.3.7.3 Recognising family dynamics

This property is related to the category changing status and also the cultural differences. The nature of this relationship means that young people are not fully independent and are responsibility is shared between parent-child. However, the nature of this

relationship changes as a consequence of the transition process, as discussed in section titled Shifting power. This change in dynamics can be anxiety provoking for both, young people and parents, which in turn can influence how each then interacts with the transition process. Therefore there was a need for professionals to be aware of relational dynamics.

CAMHs workers and the parent who participated in the study gave examples of how the continued input of parents throughout the transition helped to contain anxiety levels. The dimensions of this property were identified as *including parents* and *not including parents.* Below are examples as evidence.

Table 38: Recognising family dynamics and dimensions

Property	Dimension
Recognising family dynamics	Including parents Not including parents

> "…if there is a family that is involved you need to think about they're needs too! So….erm….because actually each will have an impact [on the other]…They have a family who are probably their main support network, 24 seven…" (Participant three, page 10, paragraph 52)

> "I gave recommendations about why involvement of the family actually contained anxiety….parents became more anxious they would then be less supportive to the young person and the young person would feed off of their anxiety and become more agitated, suspicious and paranoid and so they would then create crises in that respect…" (Participant three, page, 10, paragraph 48)

> "…when Lily started coming I attended with her, just for a bit of reassurance that she could say anything and it would be ok." (Participant eight, page 6, paragraph 32)

5.3.7.4 Wearing different hats

Throughout the transition CAMHs clinicians are expected to consider the service provision, any provision provided from external agencies and what young people are likely to receive in AMHs. In addition, CAMHs professionals are faced with overseeing

and co-ordinating the process. This included the need to be aware of and manage any conflicts that arose throughout the transition. As a result participants spoke about having to assume different roles depending on the task at hand. Participant three, when asked about her role in the transition, referred to wearing different hats, see quote below, and a decision was made to use this as the label for this property.

"well…I kind of had different hats on" (participant three, page 2 paragraph 10).

As I progressed through the analysis, it seemed the CAMHs clinicians had a range of roles in the transition process. The table below presents the dimensions of this property.

Table 39: Wearing different hats and dimensions

Property	Dimensions
Wearing difference hats	Therapist Facilitator Care co-ordinator Advocate for young people / families Expert – consultation and psycho-education Supportive figure

Below are extracts from the transcripts evidencing the dimensions.

"I was her therapist" (participant one, page 1, paragraph 8)

"well your role is facilitator" (participant five, page 23, paragraph 85)

"So my role was care co-ordinator" (Participant three, page 2, paragraph 10)

"I very much advocate empowering the families and young people" (participant two, page, 8, paragraph 49)

"…being that young person's second voice" (Participant seven, page 47, paragraph 204)

The dimension *expert* was inferred from the data. Participants gave examples of giving clinical advice and recommendations to other professionals as well as providing psycho-education to parents. Here the professional is considered as the expert, in their field. Below are extracts supporting this.

> "We can only advise…" (Participant seven, page 3,paragraph 15)
>
> "…also part of my role was doing some family support and understanding and psycho-education around illness." (Participant three, page 2, paragraph 10)
>
> "So we had helped access out of mainstream education support through our student support service and so was offering them advice and support on how to manage symptomology whilst in an education setting" (participant three, page 2, paragraph 10)
>
> "liaising with school and liaising with college" (Participant seven, page 47, paragraph 204)
>
> But also like I say supporting her with things from schooling to college, there were lots of meetings in college (Participant seven, Page 59, paragraph 264)

The last dimension related to the incidents in the text where the CAMHs professional acted as supportive figures to the service user.

> "There's this thing about looking after people and those kinds of parental qualities" (Participant five, page 11, paragraph 40)
>
> "I would go and attend with her. Initially to help her build her confidence around other people with mental health problems in such a setting" (participant three, page 2, paragraph 10)

The role that professionals assumed appeared to be linked the needs of the young person (and families) in relation to the transition.

5.3.7.5 Professional anxiety

Throughout the interviews, professional expressed their thoughts and feelings about the transition. The dimensions for this property are the influences that lead to anxiety for professionals in CAMHs.

Table 40: Professional anxiety and dimension

Property	Dimension

Professional anxiety	Having to wait Increasing workload Delays/disruptions to care Therapeutic work being undone

This may not be an exhaustive list, however these were the main concerns mentioned. The properties were identified as; *having to wait, increasing workload, delays/ disruptions to care,* and *therapeutic work being undone*. Below are some extracts as evidence of these factors. In cases where these circumstances arose there was an increased demand placed on professionals which in turn led to an increased feeling of anxiety amongst them.

> "…so I had to start picking up other people knowing that this girl was going to be discharged, or should have been discharged a long time ago…I know my diary is going to be full…" (Participant seven, page 40, paragraph 174.
>
> "Because if some of the work we have done lapses it can affect the whole family…" (Participant two, page 9, paragraph 55.
>
> "…my fear is somebody may think to change it back" (participant two, page 3, paragraph 19.)

5.3.7.6 Seeking support

In order to manage their own feelings of anxieties, participants spoke about seeking support for themselves. There were two main sources of support for professionals and these were formed the dimensions for this property, see below for examples of each. Both methods seemed to alleviate anxiety in professionals.

Table 41: Professionals seeking support and dimensions

Property	Dimension
Professionals seeking support	Supervision Discussing with the team

Below are examples for both dimensions.

> "Before we even contact adult service we would have discussions in the team." (Participant seven, page 18, paragraph 86)

> "I had to have lots of supervision…" (participant 7, page 59, paragraph 266)

5.4 Changing status

Leading on from the previous category, where it was established that the journey into AMHs marked the changing status of the service user, this category will discuss the developmental transition and how it was experienced. The category is understood in terms of it sub-categories; *'handing over'* (1), *'chronological age vs. developmental stage'* (2), *preparation for adulthood* (3) *and adjusting to change* (4). The sub-category (1) marks the end of the process as the young person has crossed the service boundary and has entered AMHs. Sub-category (2) relates to the perceptions of adulthood and describes how professionals perceive the young person as they move through the transition. How these perceptions influence the transition and preparatory work are discussed in sub-category (3), and sub-category identifies and describes a period of adjustment associated with the transition.

Table 42: Changing status and properties

Category	Properties
Changing status	Handing over Chronological age vs developmental stage Preparation for adulthood Adjusting to change

Thus far, I have presented that the transition between services is primarily determined by chronological age. When the young person reaches 18 years of age they are legally

deemed to be an adult, and so the system requires that any further support is provided by Adult services, as depicted in the excerpt below.

> "Helping them, both mother and daughter to understand that...the nature of the care should naturally shift at this stage…will naturally shift when she becomes an adult" (Participant two, page 11, paragraph 79)

5.4.1 Handing over

Within the context of this study, the sub-category relates to the issues associated with responsibility and authority to make decisions, which has been summarised as *power*. The property for this sub-category was identified as *shifting power* and *taking on the case*.

Table 43: Handing over and properties

Sub-category	Properties
Handing over	Shifting power Taking on the case

5.4.1.1 Shifting power

When the young person makes the transition out of CAMHs, the responsibility for the care of services users and the authority to make decisions, shifts from CAMHs to AMHs. Consequently, in addition to the shift of power between services, I observed an implicit process running parallel; where power also shifted from parent to the service user. The dimensions for this property have been identified as: *holding power* and *relinquishing power*.

Table 44: Shifting power and dimensions

Property	Dimensions
Shifting power	Holding power Relinquishing power

The extract below has been taken from an interview with a professional from AMHs. The participant explained the AMHs team had agreed to accept the referral of a young person below their age criteria. My interpretation of the text was that it evidenced the authority that AMHs teams had over the transitional plan, as they acted as gatekeepers and decided who comes into AMHs and who doesn't.

> "So yes, it was kind of a shared but mainly between the consultants….consultant to consultant. But also needed the back-up of the team to say yes, we'll hold this and contain him on the ward because he went straight onto an adult ward rather than into a young people's ward." (Participant three, page 7, paragraph 28)

In the following quotations participants expressed an acknowledgement of the shift in power between services.

> "So they either accept it or they don't. You know it's kind of in their hands really not ours." (Participant seven, page 50, paragraph 226)

> "…the work, even the work has got to be transferred over to adult mental health…" (Participant two, page 2, paragraph 13)

With regards to the parental power, the following quotes support the idea that parents have a responsibility in the care that service users received in CAMHs. The second quotation is an extract from a professional who described parent's role in decision making.

> "I suppose you know it's like our responsibility to make sure that she attends as much as she can and participates really. To encourage her to use the service to its full," (Participant eight, page 8, paragraph 42)

> "First of all, once they get into adult services they can discharge themselves. There's kind of like, nothing to say they have to stay in that service that's the way it should be or shouldn't be, and I'm not saying it's generally the parents that have that control really and make the decision about whether the young person will continue with support from camhs." (Participant seven, page 8, paragraph 41)

The remaining quotes highlight the difficulty that parents experience as a result of having to relinquish their power.

> "…they only come in session if our client wants them to come in. So it's a very different dynamics…the dynamics have shifted, the power is very different, as

well and its very uncomfortable and awkward for parents and they don't like that change." (Participant four, page 4, paragraph 29)

"…that is again the power and control that the person feel that they have …so I think that's going to be a very hard and long battle with the parents when their child does come into adult services…"(Participant four, page 16, paragraph 110)

"…they've already been forewarned that parents are big complainers and will complain if all services aren't involved from the onset. So we've got to offer the psychological assessment even though CAMHs psychology service doesn't feel that's needed" (Participant four, page 15, paragraph 108)

5.4.1.2 Taking the case on

Table 45: Taking on the case and dimensions

Property	Dimensions
Taking on the case	Allocating a named worker Offering psychological treatment Offering appointments Taking over medication

This property relates to the practicalities of handing over the case to AMHs. At this stage of the transition, AMHs have accepted the referral as well as responsibility for the case. I interpreted accepting the referral marked the end of the transition. This was inferred from the data, as by this point AMHs professionals began to take steps to implement the care package. The dimensions relate to the tasks that are involved in taking the case on; *allocating a named worker, offering psychological treatment, offering appointment* and *taking over medication,* to illustrate I have provided extracts below.

"…you will have an identified worker…" (Participant five, page 17, paragraph 59)

"…if they are going to come into secondary care services of any sort they're going to need a care coordinator so where there is a psychiatrist involved, there is going to be a psychologist or CPN or a social worker" (Participant three, page 7 paragraph 43)

> "…the adult services that I work with when we send out an appointment" (Participant one, page 13, paragraph 113)

5.4.2 Chronological age vs. developmental stage

The sub-category identifies the perceptions about adulthood and how they influence the transition. The properties are identified as: *perceptions about adulthood, not acting your age, preparation for adulthood.* Below is an excerpt from an interview with a professional that illustrates the disparity between chronological age and developmental stage.

> "…So they probably treated her as somebody who was very much 18 plus but from our point of view we still see that person whose going into adult, maybe, as a young person …" (Participant seven, page 9, paragraph 37)

Table 46: Chronological age vs. developmental stage

Sub-category	Properties
Chronological age vs developmental stage	Perceptions about adulthood Not acting your age Preparation for adulthood

5.4.2.1 Perceptions about adulthood

This property relates to the perceptions about adulthood. Each stakeholder's perceived adulthood in terms of *being responsible, being independent* and *making autonomous decisions*. These formed the dimensions of the property. Below are extracts evidencing these dimensions.

Table 47: Perceptions about adulthood and dimensions

Property	Dimension
Perceptions about adulthood	Being responsible Being independent Making autonomous decisions

During the interviews the parent was asked about her views on what it meant to be an adult. She gave the following response;

> "I suppose it's taking more and more control and responsibility of your own life and making the big decisions for yourself." (Participant eight, page 12, paragraph 64)

This view of the parent was shared by all participants. When participants were making judgements about the developmental stage of the young person, they described making note of factors such as independent travel to appointments, making decisions, living with parents, employment and financial status; as evidenced below.

> "I'd also just consider responsibility wise where they are…in terms of work, financially, you know that sort of….I'd take that into consideration are they working, are they living with their mum and dad. Are they independent? To what extent are they independent? Cos…yeah, there are different levels." (Participant one, page 11, paragraph 97)

> "I suppose it marks the start really of sort of us having to take a step back and Lily having to take on more for herself really." (Participant eight,

> "We're looking at independent travel. We're looking at independent living." (Participant two, page 2, paragraph 13)

5.4.2.2 Not acting your age

Based on how participants judged the young person they either referred to them as being *adult-like* or *child-like*. Both of these were identified as dimensions and are evidenced below.

Table 48: Not acting your age and dimensions

Property	Dimension
Not acting your age	Adult-like Child-like

> "And I think sometimes the behaviours that come up in the therapy sessions….they might try to be adult too quickly or they may try to remain very child-like." (Participant four, page 9, paragraph 59)

> "He's …coming up to…I'm not sure if he's coming up to or he's just had his 19th birthday…but he probably presents like a young person of about 14 /15." (Participant one, page 41, paragraph 41)

> "And acknowledge that they are still young people and sometimes, you know, they might be quite child-like…" (Participant seven, page 34, paragraph 154)

5.4.2.3 Preparation for adulthood

Professionals' perceptions about adulthood influenced the way in which they prepared young people for the transition into adulthood. There were three dimensions to this property; *supporting young people in making autonomous decisions, supporting independence* and *supporting young people in taking responsibility*.

Table 49: Preparation for adulthood and dimensions

Property	Dimensions
Preparation for adulthood	Supporting young people in making autonomous decisions Supporting independence Supporting young people in taking responsibility

With regards to making autonomous decisions, participants described how professionals in CAMHs would have more discussions with young people about decisions. These discussions served two purposes; firstly it developed the young person skills in problem solving and decision-making. Secondly, it gave professional surety that the young person had made an informed decision and that professionals had acted in accordance with ethical guidelines. The excerpts below are evidence of professionals supporting decision making.

> "…so if a young person says no I don't want to share that when they're in adult services or I don't want them having copies of my CPA's etc. etc., then I think sometimes that's taken as a definite kind of like….ok….that's your choice….your prerogative…(Participant three, page 9, paragraph 48)

> "You know we do treat them like young people and maybe not as much as like adults so they have to make decisions. We kind of like support them through that," (Participant seven, page 8-9, paragraph 33)

> "…we certainly would be having discussions about some of the things that we're going to have to think about in upcoming sessions because of their age…. again to help people make decisions about where about where their future care is going to lie" (Participant seven, page 17, Paragraph 78-79)

Below is an example of CAMHs professionals supporting the independence of the young person by accompanying her to voluntary services until she felt comfortable to attend on her own.

> "I would go and attend with her. Initially to help her build her confidence around other people with mental health problems in such a setting erm….to the point where she could do that independently and continue to access that without service support" (Participant three, page 3, paragraph 10)

The last dimension was supporting young people in taking on responsibility for their decisions and care package, which is depicted in the extract below. The participant discussed how she encouraged young people to take responsibility for appointments, but also described promoting autonomy by increasing the young person's sense of self.

> "we say no…well you're the adult and so the letter will come to you or we'll call you and re-arrange" (Participant four, page 11, paragraph 97)

> "…that's very different so for them to be able to actually trust their own feelings and emotions and be able to share them and feel that that's going to be taken on board…" (Participant four, page 10, paragraph 69)

> "…and to put them to the test and to realise that actually it's not as bad or not as scary to get the bus to ourselves or you know…and to .,.maybe go out and try some of the home tasks maybe they've been given to do on their own and things like that that actually its ….they've quite enjoyed it…" (Participant four, page 17, paragraph 124)

5.4.3 Adjusting to change

This sub-category was inferred from the data. The transition created changes in the lives of young people and families. Firstly they have to adjust to the new roles, responsibilities and status. Secondly, parents also have to adjust to their own changing role within services. In the previous category, participants acknowledge that young

people and families can struggle to acclimatise to AMHs services, and can experience the transition as somewhat of a cultural shock. Here, the adjustment relates more to the changing status and how families and young people adjust. The properties identified were: *feeling nervous about change, adapting to change, not adapting to change*, and *level of adjustment*.

5.4.3.1 Feeling nervous about change

When asked about how young people and families felt about the changing status, participants described how most reported feelings of anxiety. Although there are other emotions that are expressed it seemed that anxiety was the most commonly reported emotion.

Table 50: Feeling nervous about change and dimensions

Property	Dimension
Feeling nervous about change	Feeling anxious Not feeling anxious

Based on the analysis there were two dimensions *highly anxious* and *not feeling anxious.* See quotations below as evidence.

> "it was very clear from the young person that although they liked the idea of that that felt very scary to comprehend." (Participant three, page 5, paragraph18)

The following quote is the response from the young person when asked how she felt about becoming an adult. This was seen to evidence the dimension not feeling anxious.

> "Y – it doesn't bother me" (Participant six, page 27, paragraph 204)

5.4.3.2 Adapting to change

This property focuses on how well the young person adjusted to the changes. Participants described a number of behaviours/ actions that had been observed in young people. These were considered to be markers that the young person had adjusted to the

transition and their new adult status. The dimensions were the range of behaviours/ actions observed when someone had adapted to the changing status; these were *making autonomous decisions, being more confident, feeling more competent, attending appointments on their own, willing to try new things, separating from parents* and *travelling independently*. The ability to accomplish more of the dimensions was related to a greater level of adaptation.

Table 51: Adapting to change and dimensions

Property	Dimension
Adapting to change	Making autonomous decisions Being more confident Feeling more competent Attending appointments on their own Travelling independently Willing to try new things Separating from parents

Some of these were inferred from the data, for example, participants noted that without parents present a service user had begun travel to appointments independently, the young person then went on to question what other tasks she could do. In one extract, the perception was that the young person attending appointments on her own meant that she felt more confident and competent in her ability to do things on her own. Her willingness to try new things was also interpreted her separating from parents.

> "…there are lots of other things that a client realises that if mum doesn't come to this appointment I can make it on my own so what else could I also start to do on my own and it really did help her do a lot of that…" (Participant four, page 16, paragraph 116)

The expectation within AMHs is that young people be more independent, responsible and make decisions for themselves. The example above indicates how the young person was beginning to develop autonomy, which can be observed in their actions. This shift in mind-set is evidenced in the quotation below.

> "..the client then realised that she could actually do it herself.." (Participant four, page 16, paragraph 116)

Participant three, talked about supporting a young person in accessing voluntary service for mental health service users. She noted that after a while, the young person was able to attend without her support. This was another example of young people becoming more independent, and hence was a marker of adjustment.

> "…to the point where she could do that independently and continue to access that without service support…" (Participant three, page 3, paragraph 10)

According to participants making decisions and taking responsibility, were significant characteristics of adulthood, and there was an expectation that young people demonstrated these in AMHs. The AMHs professional described working with a young person who made the transition, and after some time the young person requested a change in venue. I viewed this as an indicator of the young person taking more responsibility for themselves, as well as their treatment.

> "They might say well this location is easier if I can come on my own cos you know the bus takes me right there" (Participant four, page 8, paragraph 51)

5.4.3.3 Not adapting to change

In addition to those who appeared to be adapting to the change in services, there were also a number of young people who did not. The property relates to the latter, the dimensions relate to words used to describe a young person who was struggling; *not feeling ready*, *feeling out of place* and *dropping out*.

Table 52: Not adapting to change and dimensions

Property	Dimensions
Not adapting to change	Not feeling ready Feeling out of place Dropping out Relying on parents

In instances where participants described a young person struggling to make adjust, they made reference to how the young person either described feeling they were not ready to make the transition, relied on parents, felt out of place or disengaged from services. Below are some extracts as examples.

> "J - I think sometimes they do and sometimes they don't and sometimes you look at them and think you know, you're not ready for this responsibility." (Participant five, page 43, paragraph 191)
>
> "…there's no real preparation done for parents…" (Participant four, page 14, paragraph 97)
>
> "So they don't see younger people around either, so that can be a bit daunting at times for them as well" (Participant four, page 4, paragraph 28)
>
> "…and for some who can't do it they may opt out of services and not bother. Because they can't do that or they find it too difficult" (Participant four, page 4, paragraph 26)

5.4.3.4 Level of adjustment

The level of adjustment relates to the subjective feelings of service users. Whereby they either reported feeling prepared or not feeling prepared, these form the dimensions of the property. The level of adjustment was seen to be connected the level of preparatory work that was conducted prior to the transition. Meaning if young people had been made aware of the differences, they were kept informed about the process and knew what to expect, they are more likely to feel prepared. In addition, if they have been

supported in making decisions and in developing a sense of autonomy and independence again they are more likely to adjust to the transition.

Table 53: Level of adjustment and dimensions

Property	Dimensions
Level of adjustment	Feeling prepared Not feeling prepared

Below, I have provided quotations illustrating both dimensions.

> "You get some who can make that change or some that are very kind of blasé" (Participant four, page 11, paragraph 72)

> "They're a bit more savvy and they can go out and be quite confident and comfortable travelling on their own or with friends. All of that is kind of daunting to Lily and she would usually try to arrange for me to do it with her, if she could. " (Participant eight, page 38, paragraph 187)

> "I the biggest factors in getting parents prepared for the change of what you may or not be privy to" (Participant six, page 25, paragraph 184)

5.5 Reflections on the process

The theory thus far, has elicited two processes that occurred simultaneously, the transition between services and the transition into adulthood. The category, manoeuvring the boundaries encapsulated the organisational factors. It described and explained how the transition is triggered by the changing status of the young person, and hence dictated which service was responsible for the provision of care. As a result of the changing status there was an expectation that parents and CAMHs professionals relinquish their power (i.e. their responsibility and authority). Power then shifts into the hands of young people and AMHs clinicians.

Both processes were viewed as a period of change, and resulted in young people and parents moving out of CAMHs and adolescence, where there was a sense of familiarity and moving into uncharted territory, i.e. AMHs and adulthood. Professionals

empathised with young people and parents by stating that any change would naturally result in some form of discomfort or anxiety. The experience of anxiety is partly buffered by professionals as detailed in sub-category ironing out the differences, where the theory explains how professionals use various strategies in order to reduce anxiety levels. Whilst discussing their experiences there was also evidence of stakeholders reflecting on what the transition meant for them. This category is my interpretation of their reflections.

The category is divided into three sub-categories, the first *intrapersonal processes*, focuses on what the transition meant for each individual. The second sub-category focuses on changes in relationships and is titled according to the change that is experienced by each stakeholder. The final sub-category *other considerations*, are my interpretations of incidents in the text where participants seemed to be reflecting on the process as a whole.

5.5.1 Intrapersonal processes

As aforementioned this property focuses on the meaning attributed to the transition from the perspective of each stakeholder. The experience of the transition was dependent on the how stakeholders made sense of it. If the experience was seen to be a positive experience then stakeholders described the process in positive terms, whereas if participants viewed it as a negative experience they then attached negative feelings. The properties for this sub-category are the meanings or the reflections of stakeholders about their own involvement in the process, they have been identified as *becoming an adult, re-evaluating parental role,* and *fulfilling their role*. Therefore the dimensions for each were the emotional responses attached; which were either *positive or negative.*

5.5.1.1 Becoming an adult

Upon reflecting on the process, it seemed that participants viewed the transition between services as another life transition. In my interpretation the transition could be viewed as a marker for adulthood that is specific to young people with mental health issues. Below is an evidence of my interpretation.

> "It fits in with the life transition and those sorts of things." (Participant five, page 25, paragraph 93.

Table 54: Fulfilling their role and dimensions

Property	Dimensions
Fulfilling their role	Positive negative

In the extract below the participant is making the link between the developmental process and the service transition.

> "So the notion of going into adult service is reinforced by where they are at in their life, because all of a sudden they are coming to the end of their school life. Are they going to go to university? Are they going to leave school? Are they going to college?…so there are a lot of decisions to make at that time." (Participant five, page 24, paragraph 93.)

Throughout the transcripts, although anxiety appeared to be the most commonly associated emotion, participants also described some variation. Depending on how they experienced the transition(s) appeared to determine whether they attributed *positive* or *negative* emotions. These were identified as the dimensions for this property and below are illustrations of both.

> "…there are others who have just been absolutely relieved…" (Participant four, page 3, paragraph 20.)

> "…there are some who are very angry." (Participant four, page 11, paragraph 77.)

5.5.1.2 Re-evaluating parental role

As discussed in the last category, the move between services created changes in the relationship between parent and child. As a result parents seemed to be re-evaluating their role. The discourse of the parent, identified the different aspects of parenthood and focussed on what it meant for them to be a parent. However, as they spoke about their role, there was also recognition that the service user was a budding adult and the parent implied a need for her to *step back*. From this I interpreted that she was referring to reducing her level of involvement in her daughter's life particularly as she could see the young person was becoming more independent.

Table 55: Re-evaluating parental role and dimensions

Property	Dimension
Re-evaluating parental role	Positive Negative

The excerpts below seemed to depict the journey for parents. The first quote is from the parents as she talked about her daughter being able to engage with services on her own. The second is her acknowledgement of the period of change. The final quotation is her reflections on how she viewed her new role as a supportive figure.

> "…like she could do this on her own. You know." (Participant eight, page 9, paragraph 48)

> "I suppose it marks the start really of sort of us having to take a step back and Lily having to take on more for herself really…" (participant eight, page 31, paragraph 156)

> "I feel like she can do it with support, but I think that…that is where I still feel we come in as parents. You know, she still needs us to perhaps to give her a bit of prompting or reminders and…." (Participant eight, page 13, paragraph 68)

This however, was not the case for all parents, and the other participants described how in some cases parents reported feeling detached and left out, as detailed earlier in the

findings. Therefore I concluded that similar to young people, depending on the meaning that parents associated with their changing role, determined how it was experienced. So for those who viewed their changing role in positive terms, they attached positive feelings and vice versa. Below are examples of the dimensions, i.e. *positive* and *negative* emotional responses.

> "So I'm quite optimistic" (participant eight, page 27, paragraph 134.)

> "…if she doesn't want to tell me anymore then you know, I won't be able to support her because I won't know what the problem is!" (Participant eight, page 15, paragraph 76)

> "I suppose as a parent it, it's frightening because you've been involved in like the care up until now and it's like somebody saying well you're out" (Participant eight, page 17, paragraph 86)

5.5.1.3 Fulfilling their role

Professionals appeared to be reflecting upon their involvement, by evaluating their role within the transition process. For professionals, the emphasis was on whether they had fulfilled their obligations and responsibilities as a professional. This can be seen in the quote below.

> "…so all you want to do is your job." (Participant two, page 6, paragraph 115)

Table 56: Fulfilling their role and dimensions

Property	Dimensions
Fulfilling their role	Positive Negative

The outcome of their decisions and the outcome of the transition as whole were what influenced how professionals felt about the transition. For example in the extract below the participant described feeling reassured she had made the right decision. This evaluation was based on the outcome of a particular case. She had described how she felt she has pushed the young person into adult services and had been questioning

whether she had made the right decisions. As it transpired the young person had deteriorated and needed further intervention. In this case the participant interpreted the transition in positive terms.

> "She needed more therapy so in terms of that I feel that I did do the right thing. ……So yeah, I think that might have re-assured me." (Participant seven, page 55-56, paragraph 254-256.)

Other examples of professionals reflecting on their experience are presented below. Both quotes are from the same professional talking about two different cases. In the first she explained earlier in the interview that the young person who had initially expressed feelings of anxiety and fear for what the future may hold for the young person. However after having made the transition the young person had contacted the professional and informed her of the progress she had made and her acceptance at university. In this example, the transition had been viewed in positive terms. With regards to the second example, the professional talked about how the young person had interpreted the transition as a rejection, and so in the eyes of the service user the transition had been deemed to be a negative experience.

> "…I think well actually if we had done things any differently would it have been any smoother and I'm not sure that you can always" (Participant three, page 4, paragraph 14)

> "she was going to feel rejected however it had been because I think she then made that choice…..and it's difficult to know whether it would have been better to have transferred her straight away rather than starting that engagement here at the time…..(Participant three, page 16, paragraph 86)

Although the focus is on how the young person had given the experience meaning, implicit in these statements is the professional's evaluation of their own role in the transition. As in both, she concludes with a question of whether she could have done it differently. Therefore my interpretation of the text resulted in the dimensions as being; *having done enough* or feeling like they *could have done more.*

5.5.2 Changes in relationships

The transition was interpreted as leading to a change in the relationships between stakeholders, as it marked the end of CAMHs involvement and the beginning of the relationship with AMHs. The first property of this sub-category identifies the different types of relationships that are seen in CAMHs and it titled *established relationships*. The most significant was deemed to be the therapeutic relationship; this formed another property and is titled *therapeutic relationships.* The next property defines the therapeutic relationship depending on how it was experienced by both professionals and service user. Nearing the end of their time in CAMHs discussions centred on the concerns expressed by young people about meeting their new AMHs worker. I elicited the main discussions points, and clustered them under the titled *starting from scratch*. The title was chosen as it was seen to capture the general feeling of young people and parents. Lastly the final sub-category encapsulates the experience of those who did not make the transition, as this also deemed to be a change in relationships.

5.5.2.1 Established relationships

I noted that there was a difference in the types of relationships that were formed. There were new relationships and established relationships; this property focusses on the latter. I noted there were three main types, *therapeutic relationships, working relationships* and *relationships with parents.* Below are examples of each.

Table 57: Established relationships and dimensions

Property	Dimensions
Established relationships	Therapeutic relationships Working relationships Relationships with parents

The therapeutic relationship, primarily relates to the interactions between the young person and their CAMHs worker.

> "we had a good relationship...we were working though some of these issues and it was kind of a crucial time for her." (Participant 1, page 3, paragraph 26)
>
> " I think its very difficult, because often ones who need transition are young people who have been involved and built a therapeutic relationship...for quite some time and built some trust." (Participant 3, page 9, paragraph 46)
>
> " people have been very anti initially. Wanting to know what does this mean? Again I think a lot of it is about the therapeutic relationships." (Participant 3, page 17, paragraph 90)

The interactions between professionals were defined as a working relationship.

> "I mean I was in quite a unique position in that I had experienced adult services so I knew some faces." (Participant 3, page 5, paragraph 20)

In the extract below the participant is referring to her relationship with a parent. An interesting finding was the relationship between CAMHs professionals and parents. As stated earlier in the category, manoeuvring the boundaries, often parents can be heavily involved in the care of their child and in some instances they themselves can be a client of CAMHs as they too undergo some form of therapeutic intervention. Thus, a decision was made to include this as a significant relationship in the process.

> "She's got a relationship with me, she's aware that I very much advocate for ensuring that her wishes are adhered to." (Participant 2 page 10, paragraph 69)

5.5.2.2 Young person's experience of therapeutic relationship

Of the various relationships, the therapeutic relationship was perceived to be one of the most significant. This was because participants described how anxiety was contained within the therapeutic relationship. See table below for dimensions of the property.

Table 58: Young person's experience of therapeutic relationship

Property	Dimensions
Young person's experience of therapeutic	Feeling understood

relationship	Having familiarity Feeling supported

Participants reported on how young people experienced the transition, these can also be understood as the defining features of the relationship. The dimensions relate to the descriptions provided: *feeling understood, having familiarity* and *feeling supported.* Below are some the descriptions from the text.

> " she like understands me" (Participant 6, page 18, paragraph 130)
>
> " You get to know each other, you get to know each other's ways, and I guess just generally build up that trust and rapport." (Participant 7, page 12, paragraph 51)
>
> "…I think there is a safety net within CAMHS...it's comfortable" (Participant 3, page 15, paragraph 84)

5.5.2.3 Professionals experience of the therapeutic relationship

In the last section I provided the experience of the therapeutic relationship from the perspective of the young person. This property identified the therapeutic relationship from the professional's perspective. The dimensions for this property were identified as: *being there, being respectful, being caring* and *showing understanding.*

Table 59: Professionals' experience of the therapeutic relationship and dimensions

Property	Dimensions
Professionals' experience of the therapeutic relationship	Being there Being respectful Being caring Showing understanding

Below are examples from the transcripts as evidence of the dimensions.

"To treat that person that they are dealing with compassion and understanding and respect." (Participant 7, page 34, paragraph 152)

"…she's like been there more than the other people." (Participant 6, page 17, paragraph 126.)

" His understanding, his compassion and his care towards that young person" (Participant 7, page 45, paragraph 196)

"I listened to her, and I understood her" (Participant 7, page 59, paragraph 264)

5.5.2.4 Ending relationships

As a consequence of the transition, the therapeutic relationship with the CAMHs professional needs to come to an end. This can be difficult for young people and parents. As a result participants described the range of experiences associated with ending the therapeutic relationship; *feeling a sense of loss, wanting to maintain contact* and *losing familiarity.*

Table 60: Ending relationships and dimensions

Property	Dimensions
Ending relationships	Feeling sense of loss Wanting to maintain contact Losing familiarity

Below are illustrations of young people and parents experiencing a sense of loss.

"..Am I going to lose all communication, am I going to be able to share my concerns" (Participant 3, page 10, paragraph 48.)

"…there's a part of them that feels a sense of grief and loss." (Participant 4, page 11, paragraph 77)

"…part of me was sad that it had ended" (Participant 7, page 58, paragraph 262)

One participant described how, in spite of knowing the limits to the therapeutic relationship, the young person had made contact via social media after having been discharged. I interpreted the young person's actions as demonstrating her sense of loss, and her way of managing those feelings led to her desire to maintain the contact.

> "…she'd actually found me on [social media] despite having quite high setting"(Participant 7, page 58, paragraph 262)

Participants described how often young people who are making the transition would have been in the service a long time and would have an established relationships with their therapeutic worker. Therefore there was a perceived sense of familiarity and comfortability for young people and parents within CAMHs. Therefore ending this relationship was, in some circumstances, a difficult process.

> "I think there is this safety net within CAMHS….it's comfortable" (Participant three, page 15, paragraph 84)

> "I can be working with somebody for quite a long time" (Participant seven, page 11, paragraph 49)

> "But they have been in the service along time and they've had intensive work I think it is quite a…almost an ordeal to be discharged or transitioned because of the attachments and stuff really" (Participant five, page 26, paragraph 97)

One of the main aspects about the therapeutic relationship was the fact that there was a level of trust that had been developed. This appeared to be the point that was more prominent in the discussion about endings.

> " we had just part that point where she trusted me she was opening up." (Participant 1, page 4, paragraph 30)

> " young people who have been involved and built therapeutic relationship...erm...for quite some time and built some trust." (Participant 3, page 9, paragraph 46)

5.5.2.5 Starting from scratch

This property, although is taken from the perspective of professionals, and how they summarised the thoughts and feelings of young people about making the transition and having to meet new professionals. Clinicians spoke about preparing young people through discussions in therapeutic sessions. The dimensions are the range of issues that had been raised. The cumulative effects of these issues were the basis of the anxiety that

was experienced by young people, which then contained within the therapeutic relationship.

Table 61: Starting from scratch and dimensions

Property	Dimensions
Starting from scratch	Getting to know someone new Worries about feeling judged Building trust Having to repeat their story

Some of the dimensions were associated with relational factors such as *getting to know someone new* and *worries about feeling judged*.

> " yeah potentially...and maybe treated in a different way because that other person has the knowledge about them" (Participant 7, page 14 paragraph 67)
>
> "she also mentioned that she would find it difficult starting fresh with someone else" (Participant 1, page 4, paragraph 31)
>
> "…its probably because I know the people here more than I do there" (Participant 6, page 27, paragraph 199)

Furthermore, *building trust* was also identified as a significant relational issue.

> " the person that has to gain our trust is our client" (Participant 4, page 9, paragraph 57)

In addition to the relational issues, participants also attributed significance to young people *having to repeat their story.* In some instances, particularly where the young person had experienced trauma, participants described the worries of young people's about having to retell their experiences.

> "…it almost feels as though they are beginning from scratch." (Participant 4, page 4, paragraph 26)
>
> "…so for the young person they may have to tell their story or concern again." (Participant 5,page 9, paragraph 30)

"…so they want a full history and that young person may not want to be reminded of that." (Participant 7, page 13, paragraph 55)

Although participants described the worries of young people making the transition, the relationship that they develop with their AMHs worker is also defined as a therapeutic relationship. Therefore a lot of these issues were managed or resolved within the therapeutic relationship with the new AMHs worker, as it formed the basis of the work.

5.5.2.6 Feeling the gap

For those young people who did not make the transition, whether that is because the referral did not meet criteria or because of a refusal to make the transition, there were often negative feelings attached. The variations in feelings were summarised under the headings of; *left in limbo* and *being left behind.*

Table 62: Feeling the gap and dimensions

Property	Dimensions
Feeling the gap	Left in limbo Being left behind

The first dimension, *left in limbo*, describes the feeling associated with situations where communication between the young person and AMHs had been poor. The lack of communication meant that although young people were aware they would be discharged from CAMHs, they were unaware of what would happen after. This amplified the feelings of anxiety related to the transition. Below is an example of this.

" She was left in limbo not knowing" (Participant 7, page 44, paragraph 192)

The term was also used by participants in relation to the gaps between services caused by the difference in age boundaries for services. Therefore those who did not meet age criteria for AMHs were also described as having been left in limbo. The except is taken

from an interview where the participant had spoken about this situation occurring, I have provided this as evidence

> "Sometimes its quite scary that young people in some way are left in limbo" (Participant 2, page 6, paragraph 37)

Furthermore, in these circumstances, participants also described young people as having been left behind.

> "… so he's nearly 19 and he's watching young people, other clients, younger than himself coming and going, but he's still here at 19" (Participant 2, page 13,paragraph 93)

5.5.3 Other considerations

This sub-category takes into account considerations of the current practice of transitions across mental health services. In each of the transcripts participants reflected on the process, this sub-category encapsulates my interpretation of these discussions. The properties were identified as: *discharging vs. making the transition, not accounting for developmental factors who's paying, psychological formulation diagnostic criteria's* and *having multiple assessments.*

5.5.3.1 Discharging vs. making the transition

This property relates to the meaning young people attach to either being discharged or having to make the transition between services. It appeared that some young people attached the concepts of success and failure to the progress made in therapy. Some participants associated discharge from services as an indicator they had succeeded in therapy, as they were deemed to have made enough progress to no longer require input from services. For those who made the transition, some young people interpreted a referral to AMHs as failure in therapy. The dimensions of this property were identified as *feelings of failure* and *feelings of success*. See below for examples.

Table 63: Discharging vs. making the transition and dimensions

Property	Dimensions
Discharging vs. making the transition	Feelings of failure Feelings of success

> "…however her interpretation was that she had failed. So the reason she was being transferred was because she had failed at her treatment." (Participant 3, page 16, paragraph 86)
>
> "I just feel like nothings working like and I just don't want no more support from nobody." (Participant 6, page 3, paragraph 16)

There were no incidents of success, as this was inferred based on the discussions participants had about failure. The lack of evidence of this dimension also indicates that the property had not reached saturated.

5.5.3.2 Not accounting for developmental factors

In the two other categories, there have extensive discussion about the mismatch between chronological age and developmental stage. Participants reflected on how the current structure of services and procedures for transition did not seem to adequately account for the developmental stage of the young person. My observation of the data was that CAMHs clinicians gave more emphasis to developmental factors than AMHs, as the developmental model is intrinsic to their work; whilst AMHs appeared to be focussing more so on chronological age. The dimensions for this property were *Chronological age* and *developmental stage.*

Table 64: Not accounting for developmental factors and dimensions

Property	Dimensions
Not accounting for developmental factors	Chronological age Developmental stage

5.5.3.3 Who's paying?

This property was based on the quotation below:

> "…who's going to pay for the service that's going to be delivered?" (participant two page 8, paragraph 55.)

As with most aspects of service provision there are generally cost implications associated. This property is linked to sub-category identifying the gap. CAMHs professionals spoke about the difficulty with continuing to offer support to young people passed the age boundary, despite the fact that they are not commissioned to do so. However, if they did not provide this service it would result in unmet needs.

There is a question about what happens to those young people do have on-going needs but do not meet criteria for AMHs? There is a tension here between a moral or ethical stance and the remit set out by commissioner.

5.5.3.4 Psychological formulation vs. diagnostic criteria

This property encapsulates the tension between the medical model and therapeutic model, the dimensions for this property are identified as the *medical model* and the *therapeutic model*.

Table 65: Psychological formulation vs. diagnostic criteria and dimensions

Property	Dimensions
Psychological formulation vs. diagnostic criteria	Medical model Therapeutic model

Participants discussed how mental health services have been re-structured to integrate psychological intervention within services. Based on the discussions of participants it seemed that CAMHs were more therapeutic in their approach, whilst AMHs were more medical model orientated. This is indicated in the excerpt below where the participant described AMHs are following the medical model. It is possible that this could potentially be another underlying tension between the two services.

> "…within adult services. My impression is it's more of a traditional probably medical led model" (Participant five, page 42, paragraph 187)

The therapeutic model that is commonly practiced by psychologists in the mental health system and attempts to understand mental health difficulties in terms of psychological distress as opposed to diagnostic criteria. From this model, intervention typically involves developing an understanding of the individual's distress and they do not typically focus on diagnoses. However within the medical model, professionals understand mental health problems on the basis of symptomology and diagnostic criteria. Although both services have integrated both approaches, when it comes to the transition it seemed that only diagnosis was considered as criterion for eligibility. It is possible, that this may be an underlying tension that has influencing the transition process.

5.5.3.5 Having multiple assessments

This property relates to the need for professionals to conduct assessments. This is the method by which professionals gain information about the history and development of mental health problems. This information is vital for clinical decision-making. When a professional meets a service user for the first time they will conduct some form of assessment, as it is considered standard practice. However, the participants of the current study described how this posed a problem under the following circumstances.

Firstly for those young people who enter the CAMHs service late, they would undergo a CAMHs assessment. If the outcome of that assessment results in the young person having to make the transition to AMHs, they would then undergo another assessment by an AMHs clinician. Secondly, participant described how most transitions involve the transfer of care from a consultant in CAMHs to a consultant in AMHs. As part of their practice, both consultants would then conduct an assessment of the young person's

needs, if transition is agreed as the way forward, there is the potential for the service user to have had multiple assessments as part of the transition.

In both cases, having multiple assessments can be frustrating for young people as they have to repeat the same information to several professionals. Furthermore in some cases, where young people have experienced trauma, having to repeat their story can actually be a difficult and anxiety provoking task.

CHAPTER SIX: GENERAL DISCUSSION AND CONCLUSION

6.1 Overview

The final chapter will be divided into two main sections; General discussion and Conclusion. The discussion demonstrates how the study has adequately answered research questions. It will also compare the findings with the wider body of literature that was presented in chapter one, drawing out the significant aspects of tentative theoretical model. At the end of each sub-section the implications for practice have also been included. The Conclusion will offer a critical appraisal of the research process, which comprises of two sub-sections; Implications for practice, Strength, limitations and Quality of the study; closing with the concluding remarks of the researcher.

6.2 General discussion

6.2.1 The research question and aims

The aim of the study was to propose a theory that explained the experiences of stakeholders making the transition from Child to Adult services. Consistent with the GT method, the final model, Figure 2 (The Theory: Facing the Transition, p. 99) is a tentative theory, which would need further testing before it could be accepted as a generalisable, substantive theory. As analysis progressed, it seemed there were three fundamental overarching questions that arose; when, how and why does the transition occur; what factors influence the transition and in what way? How is the transition experienced?, each question will be addressed individually. These stem from the

original three questions detailed in section 2.7. Although the discussion will include existing literature discussed in chapter one, there is a primary focus on the TRACK study (Singh 2008; Singh et al 2009; Singh et al 2010; Hovish et al, 2012; McClaren et al., 2013; Paul et al., 2013). As this is the largest, multi-site, multi-method study on the topic worldwide, it has contributed a significant amount of knowledge to the understanding of transitional care in mental health services.

6.2.2 When does the transition occur?

Transitional care has been defined as 'a situational event, where young people move from one service to another' (Singh et al., 2008, p. 2). Service boundaries are determined by chronological age of the service user. Similarly the transition is also marked by the chronological age, and is set into motion as a direct result of the service user nearing the maximum age boundary of CAMHs. However, as discussed in identifying the gap (Section 5.4.2), the findings revealed a gap that exists between services boundaries. For the participant in this research CAMHS maximum age boundary was 17 but the minimum age boundary for AMHs was 18. Singh et al. (2008) and Richard and Vostanis (2004) found similar variations in 6 different sites, across the Midlands and greater London. This suggests a lack of consistency among CAMHs services. The gap between services also increases the potential for young people to fall through the safety net that services are supposed to provide. The authors of the TRACK study (Singh 2008; Singh et al., 2009; Singh et al., 2010; Hovish et al., 2012; McClaren et al., 2013; Paul et al., 2013), argued that there is a need to be more flexible with age boundaries by having an age range within which the transition should occur, as opposed to having a cut-off age. **Implication one:** The findings of this study suggest strongly that flexibility with the transition supports a smooth transition, so this research supports the recommendations of Singh et al. (2010).

Although the age boundary for CAMHs was identified as 17 years, the transition, where possible, occurred earlier, from approximately 16-16½ years onwards. This tallied with the TRACK study (Singh 2008; Singh et al., 2009; Singh et al., 2010; Hovish et al., 2012; McClaren et al., 2013; Paul et al., 2013), where the average age at transition was identified to occur at 16 (Singh et al., 2008). It seems the reason for starting the transition at an early age is due to the fact that it is not always possible to anticipate the amount of time that the transition will require. However, despite the efforts of professionals to create a smooth, seamless transition there currently exist a number of barriers that leads to delays prolonging the transition process. This can give rise to a number of challenges for clinicians, who need to ensure continuity of care for the service user.

6.2.3 Why does the transition occur?

Based on the analysis of the data in this research (see *Continuity of care,* Section 5.4.1.3), continuity of care was defined as the continuous care provided to service users without disruption. Continuity becomes particularly important as this forms one of the fundamental reasons for why young people make the transition, (supported by Singh et al., 2008; 2008). In short, when a young person nears the age boundary, clinicians question whether there is a need for transition or whether discharge back to primary care is more appropriate. CAMHS service users who have on-going needs that require the continued support of mental health services may need a referral to AMHs. The transition is set into motion to ensure that service users receive continuous care. Governmental guidance states that the transition should be seamless (DoH., 2008, 2008), however, this study affirms the findings of the TRACK study (Singh et al, 2009): although the intention is to ensure a continuity of care, participants reported the experience is speckled with difficulties that lead to either a disruption of a delay to care.

Disruptions to care have been known to have adverse effects on the health and well-being of young people (Singh et al., 2010).

For participants of the current study, the transition was sometimes far from being seamless. As discussed in section (Section 5.4.2, *Identifying the gap)* where disruptions or delays occurred, the responsibility to ensure continuity lay with the CAMHs professional, as they still had a duty of care to the young person. In the 2012 study, conducted by Hovish et al. (2013), the authors question what happened when there were delays or disruptions if the service user was not accepted by AMHs. The findings explain how in these circumstances, often CAMHs clinicians would continue to work with young people passed the age boundary, which although ensuring continuity, results in an increased workload for the CAMHs clinicians. In addition, working with young people passed the age boundary raises a number of challenges for CAMHS, in that there is a clash between the ethical codes of practice (i.e. duty of care) and the service remit set out by commissioners. So CAMHs are sometimes left to cater for a group of young people who fall outside of their criteria and remit. It is particularly challenging for frontline CAMHs clinicians, who have to make a decision about which to prioritise the service user's needs or the service needs. In some respects one can claim that CAMHs are left to 'hold' service users until they are formally accepted by AMHs. This has other implications in terms of finances and service capacity. **Implication two:** Based on the findings of the study there was not a clear answer on how to manage such situations and it appeared that current practice involves working on a case-by-case basis.

6.2.4 How does the transition occur?

'Initiating the transition' (Section 5.4.3 of the findings) explained how the transition involved CAMHs making a formal referral to AMHs. Referrals were either made through face-to-face discussions between CAMHs and AMHs professionals or via a

referral letter. Where a referral letter had been sent, participants reported that often it led to difficulties later in the process. The theory identified that a face-to-face discussion was better than a referral letter, as it allowed AMHs professionals to connect with the individual, i.e. the service user. This is in line with governmental guidance ('Getting it right'), where emphasis is placed on a person-centred approach to transitional care (DoH, 2006, 2008).

The theory explains how in the initial stages professionals must first ascertain the need for transition and then establish whether the service user is eligible for AMHs. This involves using criteria to determine eligibility. The criteria comprised of age, diagnosis, level of risk and level of need. The most significant of the four criteria, according to the findings (see sub-category *Deciding to transition*, section 5.4.1) were age and diagnosis. These appeared to have the most influence on the decision of whether a referral will be made. This mirrors findings from the TRACK study (Singh et al., 2008) that looked at transitions and found that of 154 cases one quarter did not make the transition because of their diagnosis. The difficulty with basing eligibility solely on diagnosis, is that some of the mental health difficulties seen in CAMHs do not meet the criteria for AMHs (Paul et al., 2013; Richard and Vostanis, 2004; Singh et al., 2010; Swift et al., 2008 & Hall et al., 2013). Therefore it can be suggested that some young people with difficulties are unlikely to receive further support once they have completed their time with CAMHs. This is at odds with empirical studies which have evidenced that mental health difficulties in adolescence is a strong predictor of experiencing mental health difficulties in later life (Copeland et al., 2013; Visser et al., 2000; Keiling et al., 2011; Green, McGinnis & Meltzer, 2005; Kim-Cohen et al., 2003). Although not indicated in the findings, it is possible that those who are ineligible for AMHs might deteriorate due to lack of support and might then enter AMHs at a later point anyway. Research has already indicated that preventative support provided early can lead to greater personal,

social and economic benefits (DoH, 2011). **Implication three:** There is a need to review current support provided for this particular group of young people.

The theory presented in Figure 2 also explains that decisions about eligibility had two inter-related cognitive processes occurring simultaneously. Both processes stem from two fundamental questions implicit in the decision-making process; 'does the young person meet criteria?' and 'what is the likelihood of the referral being accepted?' Based on the interpretation of the transcripts, the first question was answered through a clinical assessment of the young person's mental health difficulties; the criteria aforementioned formed the framework for this decision. However, the second question was implicit in the decision-making process and focussed on making a prediction about whether the referral will be accepted or not. This elevated the importance of knowledge and understanding of Adult service structure and criteria. Without this knowledge there is a danger that CAMHS clinicians may not have the full facts in order to make an accurate prediction; rendering their prediction more of an assumption. In the present study, the theory Figure 2 *(The Theory)* identified a disparity among CAMHS clinicians knowledge of AMHs. This is the category called *Manoeuvring the boundaries,* Section 5.4 In cases where the participant had a lack of knowledge, there appeared to be more difficulties with the transition that often resulted in feelings of frustration and confusion. Paul et al. (2013) identified similar findings, out of 154 cases that had been investigated; about a quarter of the young people did not made the transition because clinicians had assumed that the referral would not be accepted, resulting in unmet needs. These are some of the young people who would remain in CAMHs, however as stated this raises issues about responsibility, finance and service capacity. **Implication four:** There may be some benefit in the two services to collaborate and jointly develop a 'transitional pack' that provides details about criteria and pathways into AMHs. Government guidelines have also suggested each service recruit a transitional worker,

(DoH, 2006, 2008), whose primary role is to work at the interface between the two services. However, this would require specific training, and experience of both CAMHs and AMHs, which means there would be cost implications and in light financial constraints placed upon services, this may not be seen by some as a viable option. Having said that recruiting a transitional worker would help to alleviate some of the difficulties currently faced with the transition and they would essentially bridge the gap between CAMHs and AMHs.

6.2.5 What factors influenced the transition process and in what way?

The findings of the study identified a number of barriers, (for instance, having a vague diagnosis, perceptions about the level of need, feelings of anxiety and difficulties with adjusting to change) which were all observed to disrupt the transition. This was shown in all three categories, *Manoeuvring the boundaries* (Section 5.4), *Changing status* (Section 5.5) and *Reflections on the process* (Section 5.6). A majority of the barriers were seen to stem from either the changing status of the young person or due to the organisational differences between services. In order for professionals to sufficiently prepare for and support a positive experience of the transition there is a need for professionals to be aware of the influence of both factors. According to Singh (2009) the findings revealed that in instances where professionals had not accounted for these factors it led to difficulties with the transition and raised anxiety levels.

Governmental guidelines advocate for effective joint working (DoH, 2006; Birchwood and Singh 2013) to ensure a smooth and seamless transition. However, in practice this appears to be a challenging task. The theory explains how the difference between the two services creates barriers to the transition. Each service is geared towards meeting the needs of their respective clients groups and is effective in doing so. Yet current practice does not adequately account for how the same service user [and their families]

moving from one service to the other will experience the difference. The theory presented in the previous chapter describes how in most cases it is experienced as a 'cultural shock' and can lead to feelings of confusion and anxiety (McLaren, et al., 2013; Viner, 1999; Islam et al., 2010, Hovish et al., 2012 and Arcelus et al., 2008).

In Figure 2, (The Theory) the property 'service level conflicts' (within the category *Manoeuvring the boundaries;* see Figure 4) identified how the differences between services meant there were potential obstacles preventing CAMHs and AMHs to engage in effective joint working. This was because they differed in terms of the culture, working practices, perceptions about the service user and sharing of responsibility. Organisational differences acting as a barrier to transition is not new knowledge and has been identified by Paul et al. (2013), Singh et al. (2008), Singh et al. 2010), Hovish et al. (2012), McClaren et al. (2013), Marcer et al. (2008); Swift et al. (2013), Hall et al. (2013), & Arecelus et al. (2008). However, where the current study diverges from extant literature is its emphasis on the current strategies that clinicians employ in order to reduce the impact of barriers. The next section explains how clinicians try to manage these barriers.

6.2.6 Ironing out the differences

The sub-category, 'ironing out the differences' (Section 5.4.6) explains how professionals try to mediate the conflicts that arise due to the organisational barriers. The participants spoke about the benefits of being flexible, accommodating and tailoring the transition to the needs of the service user. For instance participants gave examples of altering the length, pace and structure of support that AMHs will provide, accommodating parents, as well as exercising some flexibility with age criteria, which was also a recommendation of the TRACK study (Singh et al., 2010). **Implications five:** For professionals to be accommodating, flexible and meet individual needs, they

would need to pay particular attention to the developmental, educational, and mental health needs of the young person. In order for them to do this, professionals would need to engage young people in the process which could potentially increase service user involvement. By doing so services would be catering for the individual needs and thus be more in line with governmental guide-lines which recommend a person-centred approach to transitional care (DoH, 2006). It was clear from the data the clinicians would welcome these opportunities to be more person-centred but felt inhibited by time constraints and heavy workloads.

The sub-category *Ironing out the differences* (Section 5.4.6) also describes the importance of having joint meetings, where all stakeholders, including parents, can be a part of transition planning (see Section 5.4.6.4, *Joint meetings*). Joint meetings have several benefits in that they allow for the fluid exchange of relevant information; it allows for discussion to take place where all parties can negotiate the transitional plan so that it meets the individual needs of the service user and family. This was seen to reduce anxiety, thus improving the experience and limiting the possibility of service users disengaging. Additionally, professionals are able to negotiate clear roles and lines of responsibilities, all of which will result in a mutually agreed plan. Having everyone agree was also considered crucial as evidence seemed to suggest that without mutual agreements the transition often resulted in a protracted and difficult experience. Furthermore joint meetings supplement working relationships with clinicians from both services, and have the potential of increasing clinicians understanding of both services; also an important factor. However these strategies were not always present, which seems to suggest that there is variation in how professionals manage the transition. The theory identified that when professionals applied each of these strategies it resulted in a smooth transition and was a more positive experience. **Implications six:** Managing the transition as set out in the theory, could potentially encourage a greater degree of

standardisation to transitional care, whilst also bringing it in line with the (DoH, 2006), document 'get it right' where emphasis was placed on having a holistic, person centred approach to care, to ensure good communication and joint working between services.

A significant finding of the current study highlighted how actively reflecting upon and applying ethical codes to make decisions about transition facilitated a smooth transition. This is described in the category Manoeuvring the boundaries and is discussed in Section 5.4.6.7, *Managing ethical dilemmas,* of the findings. Each service applied ethical codes in a slightly different way, for instance, informed consent of the service users is imperative in therapeutic work, however the way in which CAMHs and AMHs clinicians obtain consent varies. This is primarily due to the developmental stage of the young person and issues about capacity and competency to make their own decisions. However, paying close attention to ethical dilemmas', codes and practices shifts the attention away from viewing the transition as a merely a tick box exercise and puts the service users in centre-stage; as focusing solely on the administrative tasks can lead to an oversight of other needs such as the developmental needs as highlighted by (Vostanis, 2005; Singh et al., 2008). Ethical codes are an integral part of professionals work and are there to aid decision making. It is also a common language that all health professionals know and understand and it may help to break down some of the communication barriers that can occur when professionals meet to discuss transition.

Implications seven: From the findings where professionals had made decisions based on ethical codes of conduct, it was seen to aid in the management of conflicts and barriers.

6.2.7 How is the transition experienced by professionals, young people and families, and how do they understand their experience?

In the model that emerged from this research, the core theme permeating throughout the transition process was the changing status of the service user. This is shown in Figure 2, and especially in Figure 1, as *changing status*, and is discussed in the findings section of the same title, Section 5.4. Here the theory explains how societal perceptions of adulthood shaped the way in which young people were viewed, whereby CAMHs perceived the young person to be an 'emerging adult' whilst AMHs viewed them as an adult. Both of these perspectives had their own set of expectations about the capacity and competence of the service user to act as an autonomous individual. However, the theory highlights the disparity that exists between the two perspectives. It appears that professionals who view the young person as an 'adult' may be inadvertently overlooking the developmental stage that young people are at during this time.

All participants viewed adulthood as being characterised by the following; being responsible, being independent and making autonomous decisions. These characteristic are supported by and well documented in developmental theories (Arnett, 2000; Facio and Mocicci, 2003; and Macek et al., 2003). Furthermore, the findings exposed a marked variation in the extent to which young people demonstrated these characteristics, which is also supported by developmental theories (Arnett, 2000). The theory seems to suggest that young people who accepted responsibility, were more independent and made decisions on their own, viewed the transition as a positive event, and adjusted well. On the other end of the spectrum, those who showed these characteristics to a lesser degree seemed to struggle with the transition, and attributed negative feelings to the experience. The theory considers how a multitude of factors influence the experience of the transition, e.g. relationships, conflicts, differences between services. However these factors are considering the process from a systemic

perspective but do not account for all of the variation observed in the data. One way to understand the variation in the way that service users experienced the transition can be to consider the developmental process that occurs simultaneously to the move between services.

Transitional care occurs at a time when the young person is moving from child status to adult status. The general consensus of participants was that AMHs professionals considered young people to be adults and to act accordingly. However, this does not marry with developmental theory, which states that the journey into adulthood is a process that occurs over time. According to Arnett (2000) the stage of emerging adulthood occurs between the ages of approximately 18 through to the mid to late 20's. Yet, the current findings noted, similar to extant literature that the transition typically occurs around the age of 16, and generally young people will enter AMHs by their 18th birthday.

During this phase of development young people are exploring their identity and are still developing skills and internal resources that are needed to function as a fully autonomous individual. This highlights a problem with the current practice of transitional care, in that the expectations professionals may have of service users are out of sync with the developmental stage. Leaving one to question how feasible it is to expect young people to take responsibility for themselves and make autonomous decisions about their care and treatment. As most young people would not have developed the skills nor have the internal resources to manage such expectations. This could explain why some young people struggle with the transition, and find it difficult to adapt to their changing circumstances and further supports the idea for professionals to exercise some flexibility with the age criteria. This view has been shared among others who have investigated the transitional care within mental health services (Hall et

al., 2013; Arcelus et al., 2008; Singh et al., 2008; Richards & Vostanis, 2004; Singh (2009).

From an alternative perspective, developmental transition has been defined as the "change in roles and statuses that represent a distinct departure from prior roles and statuses" (Hutchison, 2011, p14). Young people in transition are approaching the age at which one would expect them to be naturally developing a greater sense of individuality, responsibility and competence in making their own decisions (Sneed et al., 2007; Cohen et al., 2003; Arnett 2000). So for professionals to have such expectations of young people is not wholly out of place with development. Rather it is the time-frame within which they expect the developmental transition to occur that is unrealistic. As studies conducted on the journey into adulthood seem to suggest the developmental transition into adulthood occurs between 18 and 25 years (Arnett, 2000).

Research indicates that the transition into adulthood is often marked by transition events (Arnett, 2004, 2007), such as moving out of the family home or entry into the workforce; as these are deemed to be events that are commonly associated with being an adult. In the context of transitional care the transition between services could also be considered a transitional event specific to young people within mental health services, as it too, marks the journey into adulthood. Either which way, similar to the transition between services, the transition into adulthood is marked by significant changes and ambivalent feelings, which can impact on the service user experience. **Implications eight**: Therefore this author proposes that it would be of benefit to the young person, if professionals incorporated the developmental needs of the individual in their decision making when planning and preparing young people for transition. Additionally, it may be useful (if not imperative, as the findings suggest) for professionals be aware of developmental theories/ studies such as Erikson (1965), Sneed et al., 2007; Cohen et al.,

2003; Arnett 2000; 2007; Hutchinson, 2011) as a means to assess the developmental needs of young people, so that these can be accounted for in the transitional plan for. This would also mean that the transitional plan for young people would be catered towards their individual need and may in fact reduce the potential for conflicts or disengagement. Over recent years, there has been a real drive and emphasis on evidence-based practice, by incorporating developmental theory into current practice around service transitions, services would be demonstrating this. It may also encourage more standardised practice across the board, and would eliminate individual differences amongst professionals.

Developmental theories could also help in understanding the experiences of parents. The theoretical model presented in Figures 1 and 3 explains how the transition results in parents having to relinquish their power, and reduce their involvement in the care of their child. The category *Changing status* shown in Figure 1 and discussed in Section 5.5.1, *Handing over,* and also re-evaluating the parental role, Section 5.6.1.2, highlights how parents also experience a change in role that requires some level of self-awareness and adjustment. The participant's stories showed there was variation in how some parents experienced the change in role. In most respondents, parents struggled with adjusting to the changes and sometimes disrupted or delayed the transition as a consequence (see findings sub-category *Points of conflict,* Section 5.4.5, and *Imposing support,* Section 5.4.5.3). Again, this echoes findings of developmental studies of emerging adulthood and can be understood by the developmental process of separation-individuation (Blos, 1967). In the process of becoming an adult young people begin to develop a differentiated sense of self and physically and psychologically begin to also separate from parents (Kins, Soenens and Beyers 2011). The relationship moves from parent-child relationship to one where they are perceived be of equal status (Aquilino, 1997; Kins, Soenens & Beyers, 2011; Cooper, 2007; Seiffge-Krenke et al., 2010; Bell

and Bell 2009; Buhl 2007; Scharf et al., 2004; Kins and Beyers, 2010). Similar to the transition, the process of separation-individuation can be anxiety provoking and difficult for parents. To some extent, the degree of anxiety is determined by their own attachment needs and experience through their personal life course, the security of their relationship to the fledgling adult and the level of social support available to the parents (Cooper, 2007). On the surface there appear to be some similarities between the transition between services and the process of individuation, as both require the parents to alter their role and responsibilities in order to allow the young person to develop a sense of autonomy. However, the process of individuation that occurs as a result of the transition between services is a little contrived and young people and families are somewhat forcibly catapulted into a process that would normally occur gradually over time. Where transition into adulthood occurs between 18 to mid to late twenties, the transition occurs over a much shorter time-frame between the ages of 16-18. **Implication nine:** Therefore the author would suggest that professionals take more of an empathic stance when working with parents of service users and acknowledge that similar to young people, parents also need time to process and prepare for the changes that lay ahead. It may be worth giving parents some time to explore these issues to reduce the potential for conflicts to arise. Similar to implication eight, by incorporating theories about the process of separation-individuation and how this influence the transition, services would be ensuring that practice, is more evidence based and is meeting the needs of individual, reducing the potential for inconsistent practice and may, as a result, more adequately meet the needs of stakeholders.

In addition, an interesting finding, one which has not been previously fully acknowledged in other literature, is how to define the relationship between parents and CAMHs professionals. As stated in the background and context section, it is common for CAMHs to work closely with external agencies and parents. CAMHs provide

emotional support and psycho-education to parents, but more importantly parents are sometimes also in receipt of psychological interventions in the form of family therapy. This means that, similar to service users, parents are also engaged in a 'therapeutic relationship' with professionals. Yet there seems to be less emphasis on this relationship, as it is overshadowed by the service user – professional relationship. This could explain why some parents described feeling detached and shut out. There also seemed to be little discussion in the interviews about relationships with parents, which highlights a gap in the current theory (to be discussed in the recommendations for future research). **Implications ten:** Based on the findings there is some merit in professionals reflecting upon the parent-child relationship and also the AMHs clinician-parent relationship. If the relationship with parents is considered to be a 'therapeutic relationship' then surely there is a need to ensure that this relationship is given equal consideration to the one with the service user.

Lastly, the analysis seemed to suggest that CAMHs professionals have a huge task when supporting young people during the transition process. They are expected to support and prepare young people and families, liaise with other professionals as well as with AMHs, manage and reduce the impact of conflicts and barriers. They also are expected to complete all administrative tasks. For professionals there was an expression of frustration associated with the transition. It seemed that for CAMHs professionals transitional care can be a daunting task as noted by one participant who referred to the process as 'stormy waters'. The transition can lead to feelings of anxiety, frustration and confusion. This is because of the level of demands that are placed on them as a result of the transition, which they need to do in addition to their other duties. When the transition takes longer than had been planned, it can increase their workload and stress levels. Another factor that may explain the feelings of CAMHs clinicians could be the varied role that CAMHs clinicians are required to have during the transition process.

Participants spoke about wearing different hats, and how their role varied according to what was required for the transition to occur. Although participants viewed this in positive terms and it was seen to aid a smooth transition, this may be confusing for professionals particularly those who have limited experience of transitional care. The confusion is further exacerbated by a lack of knowledge as mentioned earlier. This can increase the likelihood for poor transitional care. **Implications eleven:** It may be worth providing some form of basic training to clinicians. This may aid in increasing clinicians awareness and understanding of the multi-faceted and complex nature of transitional care; which can then be reflected upon and monitored in clinical supervision.

Implication twelve: Furthermore, to reduce the level of confusion that can occur, it may be of benefit for clinical supervisors to provide additional support and increase clinician's knowledge about AMHs services and the transition process in general. There is a question of whether the responsibility for transition should lay with CAMHs professionals or whether it would be worth sharing this more formally with AMHs. Some of the main difficulties expressed by participants were issues relating to a lack of communication, time and understanding.

Implication thirteen: An option to reduce the potential for these issues to arise is for both service to meet regularly to discuss such matters as joint working and transitional care. This would enable better communication, working relationships and may also help to streamline the process. At present it seems that this occurs in the form of professional meetings, yet these meetings were observed to be case specific and did not seem to occur with every case. Here, the suggestion is to review the process rather than specific cases, on a regular basis, identify common patterns/ issues which lead to a difficult transition and together find alternative ways of working together.

6.2.8 The study and Counselling psychology

Studies conducted prior to this research have been conducted by those who stem from bio-medical disciplines, e.g. nurses and psychiatrists. However, the transition, as noted is a social context which encompasses intrapersonal and interpersonal process, the lived experience, emotions and development. These are generally the concerns of Counselling Psychology. Psychologists have already been named in government guidance as professionals who would have the knowledge and skills to act as co-ordinators of the process; with their expertise in communication and managing challenging situations, coupled with their expert knowledge of developmental and systemic thinking, they may be best placed to support the transition of young people.

In addition, there has been a growing number of Counselling Psychologists now working in the NHS (Strawbridge & Woolfe, 2007). With the Government stating that mental health is the business of all professionals working across agencies, this includes counselling psychologists, who are among the professionals who provide support to young people during the transition.

6.3 Critical appraisal

6.3.1 Recommendations for future research

Although the current study has offered new insights about the transition process and how it is experienced it has also raised further questions. Little is known about how young people adjust to the transition after they have entered AMHs. This would be useful information to know, as previous studies have shown that a number of those who make the transition tend to disengage from services. By gathering such information would enable professionals to further improvement the transition process and prevent

disengagement. As this would mean gathering further information about the lived experience a qualitative approach may be best suited.

Similar to previous studies, the current study identified that parents can struggle with the transition process, and in some cases, they can create conflicts during the transition process. The theory explains the consequence to parents is that they must relinquish their power and re-evaluate their parental role. However, the theory does not provide a comprehensive account of how parents experience these consequences. For instance, it does not give details of factors that parents consider to evaluate their role. Similarly, this is also true for young people, the theory explains that young people will view the transition as either a positive event or negative event, but does not give details of what factors create the difference. Potentially, a qualitative study asking what factors influences evaluation, may elicit such information. This would enable professionals to better prepare young people and parents for the transition. Furthermore it would also be interesting to conduct a qualitative study on the nature of the relationship between parents and CAMHs clinicians and how parents experience the ending of this relationship. Such knowledge could have the benefit of promoting a more empathic approach and improve the experience for parents. Also, it would enable professionals to better prepare parents for transitional care between services.

Following on from the findings of the study, the theory highlighted that a number of young people will not make the transition as a result of having a vague diagnosis. This is of great concern and can lead to an increased demand on CAMHs. Therefore there would be merit in conducting a retrospective case-note study to see whether there is a pattern, and ascertain which diagnoses are less likely to be referred and make the transition into AMHs. Additionally, the finding also identified that a number of factors create barriers or conflicts to the transition, resulting in delays/ disruptions and ultimately influences how the transition is experienced. In order to improve current

practice and to increase awareness it would be useful to explore the relationship between the conflicts, strategies, preparation, and experience. The experience could be measured in terms of level of adjustment, pre- and post- transition. By asking professionals, young people or parents to rate the level of conflict, strategies, preparation and smoothness of the transition their responses could then be compared to the level of adjustment pre- /post-transition and level of anxiety. This would elicit empirical findings about relationships, predictive and effectiveness of these elements. Alternatively, other studies could explore the relationship between containing anxiety and preparation for adulthood and see whether they are indeed effective in preparing young people for the transition. These could be measured against level of preparedness and level of anxiety. A possible hypothesis could be that including these factors in preparatory work would reduce anxiety and increase the level of preparedness.

6.3.2 Strengths, limitations and quality of the study

The study used a social constructivist grounded theory method to explore the transition process. The underlying assumptions of Social constructivism reject positivist assumptions and believe in the existence of multiple realities which are moulded by context and culture (Smith, 2008). Social constructivists claim there is no single true reality and that each individual's perspective is equally valid (Smith, 2008). Those who adhere to the social constructivist approach reject positivist assumptions about truth, reality and knowledge acquisition. This also means a rejection of the criteria that embedded with positivism. Although the author agrees and has adhered to the assumptions listed above, it does raise questions about how to demonstrate that the study has made a valuable contribution as well as demonstrating rigour and usefulness. Upon addressing issues about quality, one must first acknowledge the current debate about criteria for evaluating qualitative studies.

Quantitative and qualitative methods are embedded with different paradigms and there is stark contrast between the two in terms of the underlying assumptions about truth, knowledge and reality. The more common criteria used to evaluate quality (i.e. reliability, validity, replicability, generalisability) rely on positivist assumptions. Historically, positivist criteria have been used to determine the rigour of qualitative methods by researchers from both paradigms (Oakely, 2000). However these do not marry with the underlying assumptions of qualitative approaches (Meyrick, 2015). Some have argued that to do this is inappropriate (Howe, 1995, Yardley, 2000, Meyrick 2015) for instance when looking at the role of the researcher one paradigm adheres to the belief that the researcher is an objective agent, whilst the other embraces the subjectivity of the researchers experience and perspective. Therefore positivists will judge quality based on the reduction of researcher bias, to apply such criteria to naturalistic methods goes against the underlying beliefs of the paradigm. Yardley (2000) explains the reasons as to why positivist criteria appears to takes precedence is firstly because it is the dominant hegemony in research and the methods of evaluation are well established. Whereas the development of criteria for qualitative methods has been more challenging because of "the unwillingness of researchers to converge on a unitary set of methods, assumptions and objectives" (Yardley, 2000). There exists a vast array of qualitative methods which are embedded within diverging epistemologies and methodological approaches, therefore Meyrick (2015) argues that "one set of quality criteria could never be applicable to the vast range of approaches" (Meyrick, 2015, p. 800). Furthermore Tobin and Begley (2004), stated that one must ensure whatever criteria is used it must be in harmony with the epistemology and appropriate to the aims of the study (Tobin & Begley, 2004). Thus, adding to the complexity of developing unitary criteria. Applicability is another important factor for researchers; as it refers to

the usefulness of the findings (Smith, 2008). Increasing validity increases the readers confidence is applying findings within their context (Smith 2008).

Thus, in spite of the lack of consensus amongst researchers about the most appropriate criteria, there is still a need to assess quality. According to Yardley (2000) it is both "imperative and unavoidable" (Yardley, 2000). As in order to legitimise one's finding, one would need to demonstrate the quality using some form of meaningful criteria (Yardley, 2000; Meyrick, 2015). In addition, with the greater emphasis on the 'lay' perspective and the growing body of qualitative studies, Meyrick (2015) suggests it is crucial to consider what constitutes a good qualitative study. As a result she has put forward a pluralistic model for judging quality. This is one of the models that have been chosen to assess criteria; however a decision was also made to follow the more traditional route, and apply criteria as set out by Charmaz, who developed the social constructivist grounded theory, as this was the approach underpinning this research study.

After having conducted an extensive review of the literature and contributions from the Health education authority expert panel (HEA, 1998), Meyrick (2015) identified two core principles: Transparency and Systematicity. Meyrick considered the principles to transcend across all qualitative studies (Meyrick, 2015). Transparency relates to "*the disclosure of all relevant research processes*" (Meyrick 2015, p. 803) and systematicity refers "*the use of regular or set data collection and analytical process, any deviations are described and justified*" (Meyrick, 2015). Charmaz, (2014), identified four criteria; credibility, originality, resonance and usefulness. To demonstrate the quality of the study, the tables below provide the criteria for both methods, a brief description or considerations to ascertain whether the study has met the criteria and details of sources of evidence to demonstrate that the study has met the criteria.

After having reviewed the study using the above criteria, there a few minor issues about quality. Firstly in relation to participants, the study included the interviews of one parent and one person due to the fact that there was minimal response from these groups during the recruitment process. One explanation for this may be due to the fact the study aimed to recruit young people and parents who were in the process of making the transition. As revealed in the findings, this can be a difficult and challenging time which is filled with anxiety and uncertainty, therefore taking part in a research study would not have been a priority, as they had more pressing matter to deal with. Although the researcher endeavoured to recruit more of these groups, the lack of interest and time constraints meant that this was not possible. In knowing this, the researcher aimed to gather as much information from the parent and young people that did take part. Fortunately for the researcher, the parent was willing to take part in more than one interview, a decision was made to split the interview in two parts, and once her interview had been analysed and compared with the rest of the data, another interview was scheduled to ask more specific questions which would fill in some of the gaps of the research.

Another issue related the level of detail that was provided about the setting within which the study was conducted. Each of the participants varied in terms of their professional background and place of work, and some readers may argue there was not enough detail about either to ascertain whether the findings are transferable to other settings. This is not to say that they are not transferable, rather it indicates that the reader should exercise some level of caution when making their judgement. In addition, although there is an extensive account of the researcher's reflexive process, there has been little detail about how other factors such as the gender, race and age influenced the research. For instance, some of the participants were considerably older than the investigator, indicated by their years of experience in mental health services. The

researcher did not adequately explore how age may have shaped the participant-researcher dynamic and inadvertently influenced the manner in which the interview was conducted. Despite these shortcomings, having used the two differing criteria the author deemed the study to be of a reasonable good standard.

Table 66: Quality criteria. Taken from Meyrick (2015, p. 803-806): Table of evidence

Criteria for quality	Factors or questions to consider	Has this criteria been met	Source of evidence in text
Transparency and Systematicity should be demonstrated throughout the study	Researcher epistemological and theoretical stance should be clearly stated in the study • From the social constructivist approach, the study should demonstrate reflexivity throughout	Yes	See methodology (pp. 42-50)
	Methods • State clearly, the research aims, objectives and research question • Is the chosen methodology appropriate	Yes	Method Section (pp. 51-97)
	Sampling • Ensure there is enough detail about sampling techniques and clearly establish the rationale for the chosen technique	Yes	Section theoretical sampling and theoretical saturation (pp. 64-67)
	Data collection • Does the study include sufficient detail about how data were collected, e.g. a description of the context, and how and why there were	Partly, the study gives details about theoretical sampling and how the technique aided the analytical process.	Data collection (pp. 54-55, 58-60, 89-94) Theoretical sampling and theoretical

Criteria for quality	Factors or questions to consider	Has this criteria been met	Source of evidence in text
	changes in technique or focus	However, in hindsight, more detail about the context could have been provided, but due to time constraints and limitations on the words count. This was omitted from the study. Despite this the decision making process contained with the analytical procedure.	
	Analysis • Provide details of the journey from data to conclusion • Were evidence of all cases including those that deviated and or contradicted the emerging patterns • Has the researcher clearly stated the analytical steps of the analysis • Have they included information about interview technique • Does the study include reflections of how the researcher may have influenced the research • Does the study contain an audit trail	Yes	Method section; Analysis (pp. 60-85, 93-94) Constant comparative method (pp. 62-64) Audit trail/ analytical procedure (pp. 67-85) Reflexivity section – (pp. 86-94)
	Results and conclusions • Are the findings grounded in the data • Is there enough detail provided to judge transferability		Analytical procedure/ audit trail (pp. 67-86) Findings (Chapter 5)

Table 67: Quality using Charmaz (2014, pp. 337-338), Table of evidence

Criteria for quality	Factors or questions to consider	Has this criteria been met	Source of evidence in text
Credibility	• Has the research achieved intimate familiarity with the setting or topic? • Are the data sufficient to merit your claims? Consider the range, number and depth of your observations contained in the data • Have you made systematic comparisons between observations and between categories? • Do the categories cover a wide range of empirical observations? • Are there strong logical links between the gathered data and your argument and analysis? • Has your research provided enough evidence for your claims to allow the reader to form an independent	Yes	See literature review and background and context (pages 11-38) See analytical procedure for a discussion about how variation was accounted for. (pages 68-84)

Criteria for quality	Factors or questions to consider	Has this criteria been met	Source of evidence in text
	assessment		
Originality	• Are the categories fresh? Do the offer new insights? • Does your analysis provide a new conceptual rendering of the data? • What is the social or theoretical significance of your work? • How does your GT challenge, extend or refine current ideas, concepts and practices	The current study provides a more comprehensive account of underlying processes and how they interact with each other's. It has also illuminated the possible therapeutic relationship between parents-professionals. The theory also discusses strategies that professionals adopt, whereas previous studies have focussed primarily on identifying barriers.	See Discussion and Findings (pages 100-203)
Resonance	• Do categories portray the fullness of the studied experience? • Have you	Yes	See Findings and general discussion (pages 100-203)

Criteria for quality	Factors or questions to consider	Has this criteria been met	Source of evidence in text
	revealed both liminal and unstable taken-for-granted meanings? • Have you drawn links between larger collectivities or institutions and individual laws when the data so indicate? • Does your grounded theory make sense of your participants or people who share their circumstances? • Does your analysis offer them deeper insights about their lives and worlds?		
Usefulness	• Does your analysis offer interpretations that people can use in their everyday worlds? • Do your analytic categories offer interpretations that people can use in their everyday worlds? • Do your analytic categories suggest any generic processes?	Yes	See implications in general discussions (203-219)

Criteria for quality	Factors or questions to consider	Has this criteria been met	Source of evidence in text
	• If so, have you examined these generic processes for tacit areas? • Can the analysis further research in other substantive areas? • How does your work contribute to knowledge? How does it contribute to making a better world?		

6.4 Concluding remarks of the author

The aim was to provide a theory of the transition between CAMHs and AMHs. The study describes the transition between services as a multi-faceted and complex process that is influenced by legal, societal and organisational factors. In order to improve current practice in mental health services, there is a need for services to reflect upon and consider incorporating the factors associated with the changing status of the young person and the implications this has for parents. It would be also be of benefit to professionals to ensure they have an understanding of the differences between CAMHs and AMHs, and to consider how to communicate this difference in way that is understandable and digestible for young people and parents to understand. It would also be worth professionals reflecting upon the process and consider the transition for young people from an organisational, interpersonal and intrapersonal level as this would aid in better preparing young people for the journey that lays ahead.

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APPENDICES

Appendix 1. Figure 3: Changing Status

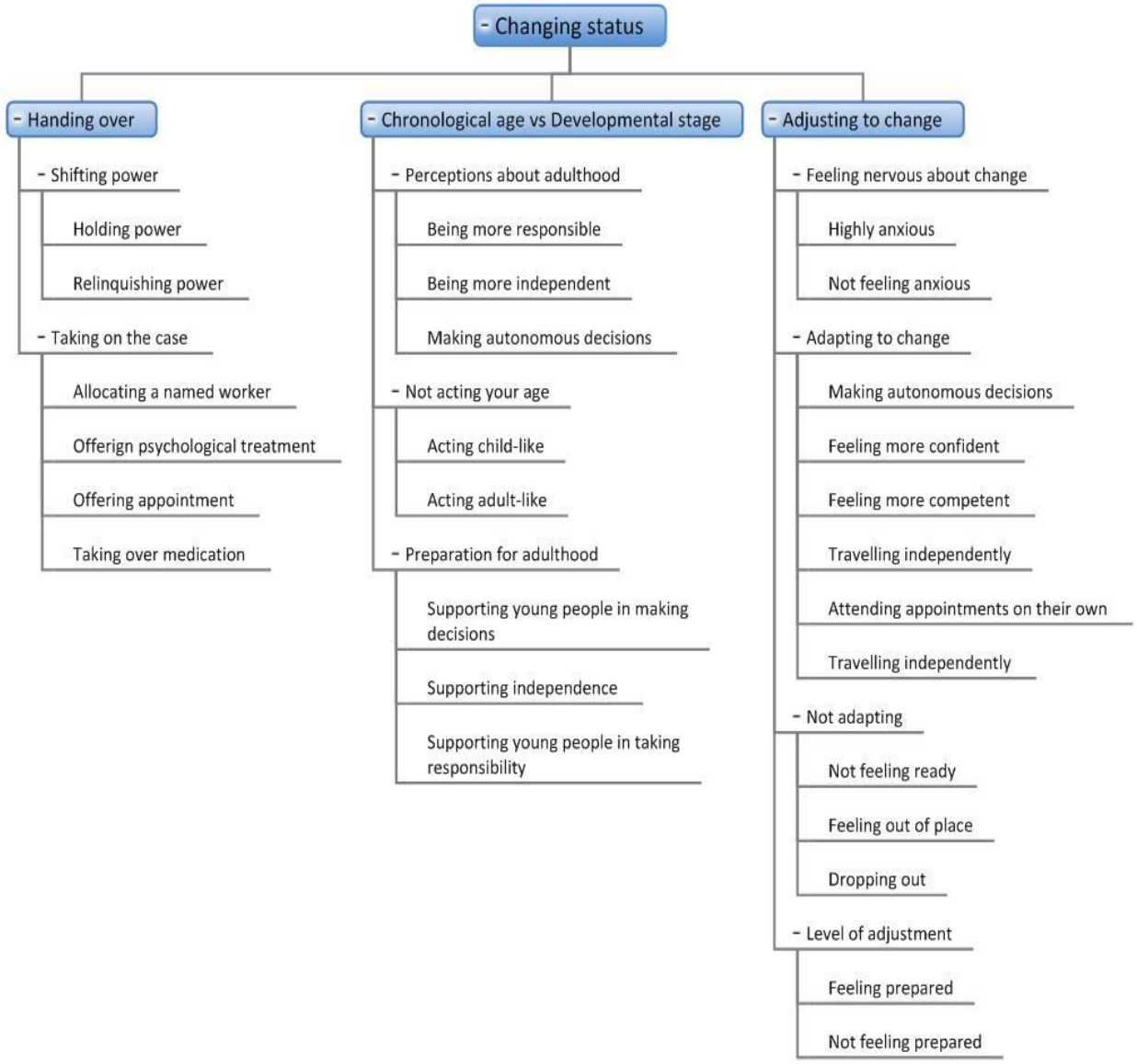


Figure 3: Changing status

Appendix 2. Figure 4: Major category, manoeuvring the boundaries

Figure 5: Major category, manoeuvring the boundaries

Appendix 3. Figure 5: Major category, reflections on the process

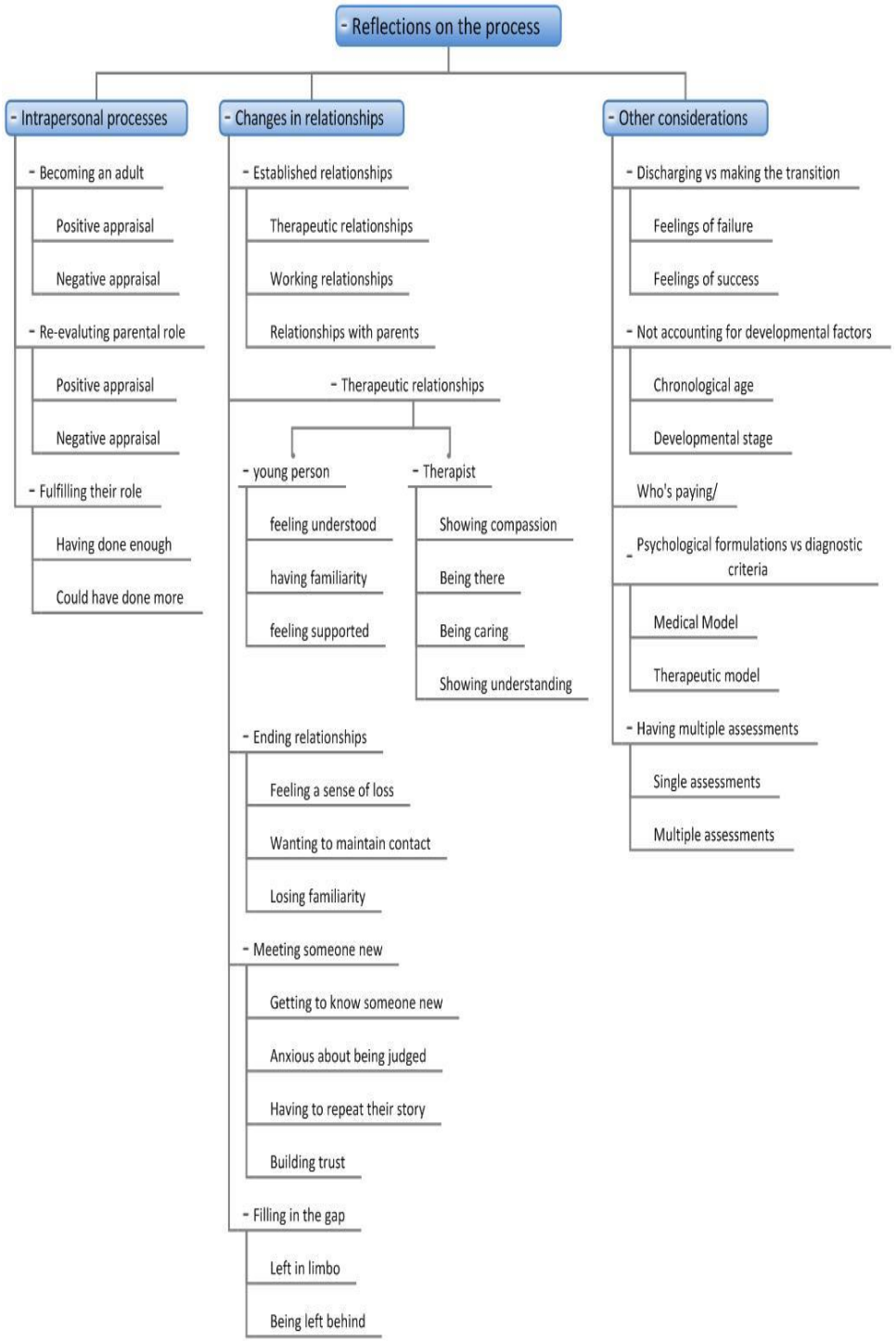


Figure 5: Major category, reflections on the process

Appendix 4. Words and phrases for search items.

Mental health transition

Transition within mental health

CAMHS to AMHS

Young people's experiences of the transition

Parents experiences of the transition

Professionals experience of the transition

Making the transition from CAMHS to AMHS

Transition

CAMHS

AMHS

Barriers to transition

Difficulties with transition

Adolescent mental health

Developmental stages and mental health transition

Prevalence rates of mental in adolescents

TRACK study

Organisations and mental health transition

Working practices and mental health transition

Policies on mental health transition

Transition between CAMHS and AMHS

Transitions between child and adolescent mental health and adult mental health

Transitions between child and adult services

Transition from child to adult services

Transition from CAMHS to AMHS

Anxiety and transition in mental health

Barriers to transition in mental health

Family dynamics and transition

Roles and responsibilities and transition

Supporting transition

Factors that support transition

What do professionals do to support transition?

Developmental factors and transition

Differences between CAMHS and AMHS

Capacity in CAMHS and AMHS

Mental health act and transition

Governmental guidance and transition

Managing the transition

Family dynamics and transition

Consent

Autonomy and transition in AMHS

Autonomy and mental health transition

Appendix 5. NHS Approval letter – conditions of favourable opinion

NHS
Health Research Authority

NRES Committee West Midlands - Solihull
East Midlands REC Centre
The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

Telephone: 0115 8839390
Facsimile: 0115 8839294

02 August 2012

Mrs Gurpreet Janjua
[redacted]

Dear Mrs Janjua

Study title:	**Exploring the experience of the transition process from Child and Adolescent Mental Health Services (CAMHS) to Adult Mental Health Services (AMHS)**
REC reference:	**12/WM/0207**
IRAS Project reference:	**56687**

The Research Ethics Committee reviewed the above application at the meeting held on 18 July 2012. Thank you for attending to discuss the study.

Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

NHS Sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

It is responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Additional conditions:-

1. The following amendments are required to the Participant Information Sheet:
   a) The wording 'required to do research' should be replaced with 'I am conducting' in section 'A little bit about me'
   b) PALS contact details should be included
   c) It should be included when the contact numbers are accessible

2. The first paragraph on the Consent Form should be removed.

3. A substantial amendment should be submitted if the researcher would like to include carers, relatives and professionals.

You must notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

Approved documents

The documents reviewed and approved at the meeting were:

Document	*Version*	*Date*
Advertisement	1	27 June 2012
Covering Letter		
Evidence of insurance or indemnity		31 July 2011
Interview Schedules/Topic Guides	1	20 June 2012
Investigator CV	Gurpreet Janjua	
Investigator CV	Dr Darren Chadwick	08 March 2012
Other: Letter Confirming Appointment	1	27 June 2012
Other: Letter from University of Wolverhampton RIHS Student Management Board		27 May 2011
Participant Consent Form	1	20 June 2012
Participant Information Sheet	1	20 June 2012
Protocol	1	20 June 2012
REC application	56687/338311/1/718	27 June 2012

Appendix 6. NHS Approval letter of confirmation

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

12/WM/0207	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely

[redacted]

Dr Timothy Priest
Vice Chair

Email: trish.wheat@nottspct.nhs.uk

Enclosures: *List of names and professions of members who were present at the meeting and those who submitted written comments*
"After ethical review – guidance for researchers"

Copy to: *Dr Darren Chadwick – Sponsor contact*

Mr Roger Abnett, Research and Development

NRES Committee West Midlands - Solihull

Attendance at Committee meeting on 18 July 2012

Committee Members:

Name	*Profession*	*Present*	*Notes*
Mrs Lynne Gray	Senior Biomedical Scientist	Yes	
Mrs Rosemary Harris	Solicitor (non-practising)	Yes	
Mrs Theresa Hyde	Retired Head Teacher	Yes	
Dr Jennifer Lim	Social Scientist	Yes	
Mrs Irene Linder	Assistant Manager, Local Authority - Retired	Yes	
Ms Veronica Morgan	Midwife	Yes	
Dr Richard Mupanemunda	Consultant Paediatrician	Yes	
Dr David O'Brien	GP	Yes	
Dr Rex J Polson	Consultant Physician - Chair	No	
Dr Timothy Priest	Consultant in Anaesthesia & Pain Management - Vice Chair	Yes	Chairing
Mr Rajeshwar Singh	Chartered Engineer - Retired	No	
Ms Gill Tomlinson	Head of Radiology, Solihull Hospital	No	

Also in attendance:

Name	*Position (or reason for attending)*
Ms Linda Ellis	REC Centre Manager
Miss Jessica Parfrement	Committee Coordinator

NHS
Health Research Authority

NRES Committee West Midlands - Solihull
East Midlands REC Centre
The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

Telephone:
Facsimile:

07 August 2012

Mrs Gurpreet Janjua
[redacted]

Dear Mrs Janjua

Full title of study: **Exploring the experience of the transition process from Child and Adolescent Mental Health Services (CAMHS) to Adult Mental Health Services (AMHS)**
IRAS Project no: **56687**
REC reference number: **12/WM/0207**

Thank you for your letter of 3rd August 2012. I can confirm the REC has received the documents listed below as evidence of compliance with the approval conditions detailed in our letter dated 18 July 2012. Please note these documents are for information only and have not been reviewed by the committee.

Documents received

The documents received were as follows:

Document	*Version*	*Date*
Covering Letter	E-mail from Gurpreet Janjua to Trish Wheat	03 August 2012
Participant Consent Form	2	03 August 2012
Participant Information Sheet	2	03 August 2012

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

12/WM/0207 **Please quote this number on all correspondence**

Yours sincerely

[redacted]
Stephen Briggs
Assistant Co-ordinator

E-mail: stephen.briggs@nnotts.nhs.uk

Copy to: *Sponsor - Dr Darren Chadwick,*

R & D - Mr Roger Abnett, Reasearch and Development

Appendix 7. Interview schedules

Professionals

The questions may vary depending on the client and their responses. However the type of questioning would not be too far from the ones listed below.

1. Can you tell me a little bit about where you have worked and the types of clients you have worked with?
2. Can you tell me about your experience of supporting someone through the transition process?
3. What kinds of things did you consider in the care package whilst working with young people making the transition
    a. Are there any things that you consider as part of the care package that you wouldn't consider with people not are going to make the transition?
    b. How do you prepare young people and families?
    c. What is age criteria? Why do they happen at that age?
    d. How much involvement do young people and families have in the transition?
    e. Others have mentioned having joint planning meetings, who attends, what do you discuss and how do they influence the transition?
    f. Can you list the kind of things you would consider in the care package?
    g. Some participants have mentioned how {insert factor] is a significant factors, what do you think?
4. What kinds of things did you do, e.g. liaison, getting information, making referrals, talking with young people and parents/ carers
    a. Who is generally involved in decision-making?
    b. How are decisions made?
    c. Do you people get involved with decision making?

    d. So, others have mentioned a change in power, and how parents are no longer involved. What is your view on this? What kind of feedback had you had from parents?

5. Who else was involved? How were they involved, what role did you and others play?
    a. How do you clarify roles?
    b. Why is this important?
    c. Who is responsible for decision-making?
    d. Some have spoken about how parents and young people can find the change in decision-making difficult, what are your views about this? How do you prepared families and young people?
6. Have you come across any challenges whilst supporting young people
    a. What factors influence the transition?
    b. How have you dealt with the challenges that you have mentioned?
    c. Others have mentioned the services can be perceived as different, what are your views about the differences?
    d. How do you communicate how the services work?
    e. How do you feel, the challenges that you've mentioned impact on the transition?
    f. Have you noticed any patterns in the types of challenges that occur during transition?
    g. How do you manage the different expectations?
    h. Some have mentioned how {factor} has made a difference, what are your views?
    i. How would you define AMHs services and CAMHs services? what sort of words come to mind?

7. Have you identified any strengths about the transition process
    a. What kinds of things help the transition?
    b. What supports a smooth transition?
    c. What do you think works well.
    d. Others have mentioned being flexible and accommodating, and how this can facilitate a smooth transition, what is your view?
8. How do parents and young people experience the transition?
    a. What kind of feedback have you had from young people and families
    b. How do you think families experience the transition?
    c. Other participants have reported a range of emotional responses, e.g. feeling angry, happy, sad, rejected? Can you think of some of the responses that young people and families have reported, and why have they felt that way?
    d. Do you think there are any other changes during the transition process?
    e. Other participants have spoken about the developmental process, what are your views?
    f. What makes the difference between those who make the transition ok and those that don't?
    g. Some participants have spoken about a change in role, how do you think families and young people experience that?
    h. How do you feel, young people and families experience the endings involved in the transition?
9. Bearing in mind your experience of supporting young people with transition, has this changed you practice in anyway, if so how?
10. What has been the most significant thing about the transition experience, is there anything that stands out more so than others?

11. Tell me about your views about the transition?
    a. can you tell me about your personal views on the transition?
    b. In your own view, what are the main concerns of young people and families at the time of transition
12. What advice would you give to other professionals
13. Is there anything you feel is important that we have not covered?
14. Is there anything else you think I should know to better understand your experience.
15. Email requesting for recruitment

Interview schedule - parents/ carers

The questions may vary depending on the client and their responses. However the type of questioning would not be too far from the ones listed below.

1. Can you tell me a little about what you know about the transition process?
    a. Where have you got this information from?
    b. What involvement have you had with the treatment of your son/daughter to date? What did you do?
2. Does this change anything for you and your family members?

(To ask only if they have also had some therapeutic sessions with CAMHs)

    a. Have you are the family as a whole been involved in any therapeutic sessions? if so what was the purpose of those sessions?
    b. How would you describe your relationship with the therapeutic worker?
    c. Is this piece of work coming to an end? And how do you feel about that?
3. When did you first know your son/daughter would be leaving the service and how did you respond?
    a. How do you feel about your son/ daughter having to make the transition to AMHs?
    b. What were your initial thoughts or feelings?
4. Who was involved? How were they involved, what role did they play?
    a. What role have you had in the transition process, if any?
    b. What decisions, if any, have you had to make?
5. Has anything changed for you since then?
    a. What have you been told about how AMHs work? what are you expecting.

b. Other participants have spoken about how AMHs work differently, what do you know?
c. Other participants have spoken about how AMHs do not involve parents or family members. How do you feel about that?
d. Has your role within the transition process changed, if so how? *Other participants have spoken about they do not have the authority to make decisions, or are not allowed to be in sessions or have an input*
e. How do you feel about your son/ daughter being treated like an adult?

6. Are there any particular positive things or negative things about the transition?
7. What has been the most significant thing about the transition experience, what or who will you remember the most?
8. Has the organisation be helpful, if so how?
9. Tell me about your views about the transition?
    a. Is your son/ daughter going through any other transitions at the moment?
    b. Are there any other factors which are influencing or could influence the transition?
10. What advice would you give to others
11. Is there anything you feel is important that we have not covered?
12. Is there anything else you think I should know to better understand your experience.

Interview schedule - parents/ carers

The questions may vary depending on the client and their responses. However the type of questioning would not be too far from the ones listed below.

13. Can you tell me a little about what you know about the transition process?
    a. Where have you got this information from?
    b. What involvement have you had with the treatment of your son/daughter to date? What did you do?
14. Does this change anything for you and your family members?

(To ask only if they have also had some therapeutic sessions with CAMHs)

    a. Have you are the family as a whole been involved in any therapeutic sessions? if so what was the purpose of those sessions?
    b. How would you describe your relationship with the therapeutic worker?
    c. Is this piece of work coming to an end? And how do you feel about that?
15. When did you first know your son/daughter would be leaving the service and how did you respond?
    a. How do you feel about your son/ daughter having to make the transition to AMHs?
    b. What were your initial thoughts or feelings?
16. Who was involved? How were they involved, what role did they play?
    a. What role have you had in the transition process, if any?
    b. What decisions, if any, have you had to make?
17. Has anything changed for you since then?
    a. What have you been told about how AMHs work? what are you expecting.

b. Other participants have spoken about how AMHs work differently, what do you know?
c. Other participants have spoken about how AMHs do not involve parents or family members. How do you feel about that?
d. Has your role within the transition process changed, if so how? *Other participants have spoken about they do not have the authority to make decisions, or are not allowed to be in sessions or have an input*
e. How do you feel about your son/ daughter being treated like an adult?

18. Are there any particular positive things or negative things about the transition?
19. What has been the most significant thing about the transition experience, what or who will you remember the most?
20. Has the organisation be helpful, if so how?
21. Tell me about your views about the transition?
    a. Is your son/ daughter going through any other transitions at the moment?
    b. Are there any other factors which are influencing or could influence the transition?
22. What advice would you give to others
23. Is there anything you feel is important that we have not covered?
24. Is there anything else you think I should know to better understand your experience.

Appendix 8. Information

Exploring experiences of the transition from Child and Adolescent Mental Health (CAMHs) to Adult Mental Health (AMHs) services

Researcher – Ms. Gurpreet Janjua

Director of studies – Dr Darren Chadwick

I am a Counselling Psychology Trainee aiming to conduct a study exploring the experiences of making the transition from CAMHs to AMHs. The study aims to develop a theory about the transition process, based upon the experiences of professionals, young people and family or carers. A total of 6 – 8 participants are required. **Below are the groups we would like to take part in the study:**

- Any chartered and **trainee counselling or clinical psychologist, or professionals** who have experience of working with young people and their families either as they are leaving the CAMHs service or as they enter Adult services.
- **Young people** who are either in the process of making the transition or have already made the transition to Adult services; and
- **Families or carers** who have supported young people with mental health difficulties at any stage of the transition process

You will be asked take part in an interview which will be audio-taped and last for approximately 60 minutes. There may be a need to conduct a follow up telephone interview in order to clarify any points. Once the analysis has been completed participants will be asked to attend a group meeting, where the results will be presented

and participants can give feedback as to whether the theory accurately depicts their experiences.

If you would like to take part in the study and feel that you fit into one of the 3 categories of participants please contact me via email [e-mail address redacted]. Please feel free to send any queries you may have also to this address. Please forward this email on to any persons who you think may be a suitable and willing participant.

Ethics

Full approval has been granted by the University of Wolverhampton Ethics committee and also NHS Research Ethics Committee.

Appendix 9. Informed consent

Experience of transition from CAMHs to AMHs

Please tick to indicate that you have read and understood each point:

☐ I agree to take part in a semi structured interview asking about my experiences, thoughts and feelings about the transition process

☐ I agree to attend more than one interview.

☐ I agree to be audio-taped, which will be transcribed and used for research purposes only. All identifiable information will be kept private and confidential and used solely for the purpose of the research; this may include writing a journal article.

☐ I realise that discussing some personal experiences might create discomfort. I understand that I am completely free to refuse to answer any questions and have the option to withdraw without any penalty.

☐ I understand that I may refuse to participate in this study and am free to withdraw from the study at any time after the study has started. I have read and understood this consent form, and I agree to participate in this study.

Supervisor Dr Darren Chadwick, School of Applied Sciences, University of Wolverhampton,Wulfruna Street, Wolverhampton, WV1 1LY, Telephone number: 01902 321 000

Signature of participant Date

Signature of Researcher Date

Appendix 10. Information sheet

To [participant]

Thank you for expressing an interest in taking part in this study.

This information pack has been sent to you to give you relevant information about the study, it is important that you make yourself aware of this information as you may find it useful at a later stage. The pack contains information about the following;

- A little bit about me
- Purpose of the study
- What the study is for
- Your rights; things you will need to know including, confidentiality and anonymity
- How to withdraw from the study
- How to get a copy of the completed study
- What your part will be

A little bit about me

I am currently training for my Practitioner Doctorate in Counselling Psychology at the University of Wolverhampton. I am also a Child and Adolescent Mental Health (CAMHs) worker and have worked within the service for several years. I am very much dedicated to my work and hence would like to further develop my practice.

As part of the doctorate I am required to conducted a piece of research and as I have a keen interest in working with young people and their families, this is the subject I have decided to investigate.

Purpose of the study

The title of this study is;

Exploring the experience of the transition process from Child and Adolescent Mental health (CAMHS) to Adult Mental Health services (AMHS)

The overall purpose of the study is to gather information about how you support young people who are in the process of leaving CAMHs, experience the transition. The idea is for us to talk about your thoughts, feelings and opinions, as I would like to understand how you and others experience the transition process.

Things you need to know

Confidentiality

Your identity will remain confidential. The details of what we discuss in the interview will be used for the study however your identity will remain anonymous. Any paperwork that has your name and address and other confidential information will be kept locked away.

Anonymity

This means that all information that reveals your identity will not be documented in the final study. All of your details will be kept locked away and will not be given to anyone else. A year after the study has been completed the confidential papers which have any of your details will be destroyed.

How to withdraw from the study

If at any stage you no longer wish to take part in the study that is your choice, however I ask that you let me know as soon as possible, as this will seriously affect the study.

How to obtain a summary copy of the completed study

If you would like a summary copy of the study once it has been completed, then please send all requests in writing to the address under contact details.

What your part will be

Firstly I would like you to read this information pack so that you are fully informed of what the study is for, what is expected of you and your rights as a participant. Once you have read the pack, if you have any further questions please do not hesitate to contact me on the number provided at the end of the letter.

If you are interested in taking part, it means meeting with me to talk about your experiences, thoughts, feelings and expectations about leaving the service whether you are moving on to another service or not, whatever the case, I would like to hear about your thoughts and feelings.

It may be that one session is not enough to gather the information that is required for this type of study and we may need to meet more than once, but this is just to make sure that I do justice to your experiences and am able to put them across in a way that it remains as close to your experience as possible. The experience is yours and it needs to remain that way, it is not my intention to judge the data, simply to understand and present it in such a way that it remains true to you.

If you are interested in taking part and wish to express your views, all you have to do is sign the two consent forms included in this pack, one of the forms is your consent to take part in the study, the other is your consent to being recorded. All recordings will be

audio taped there will be no video recording. Forms must be signed and returned to the address provided below. All forms must be received no later than 2 weeks from the date on this letter.

Contact details

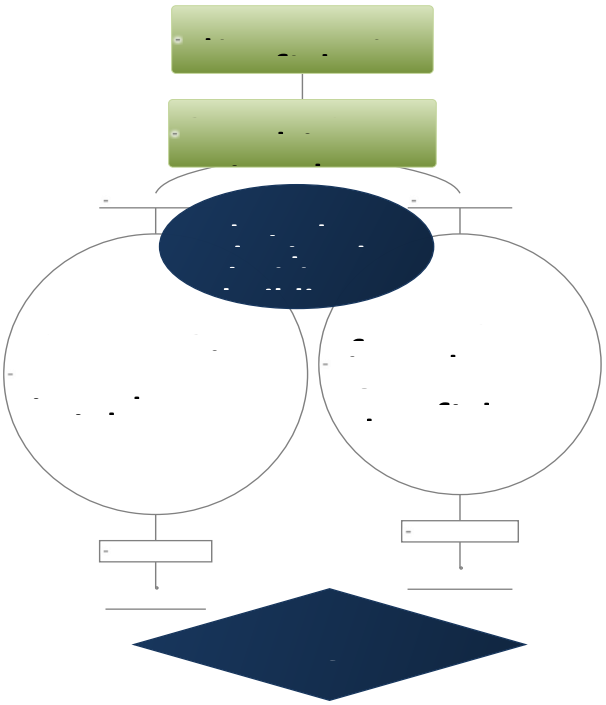
Gurpreet Janjua/ Dr Darren Chadwick

1 Wulfruna Street

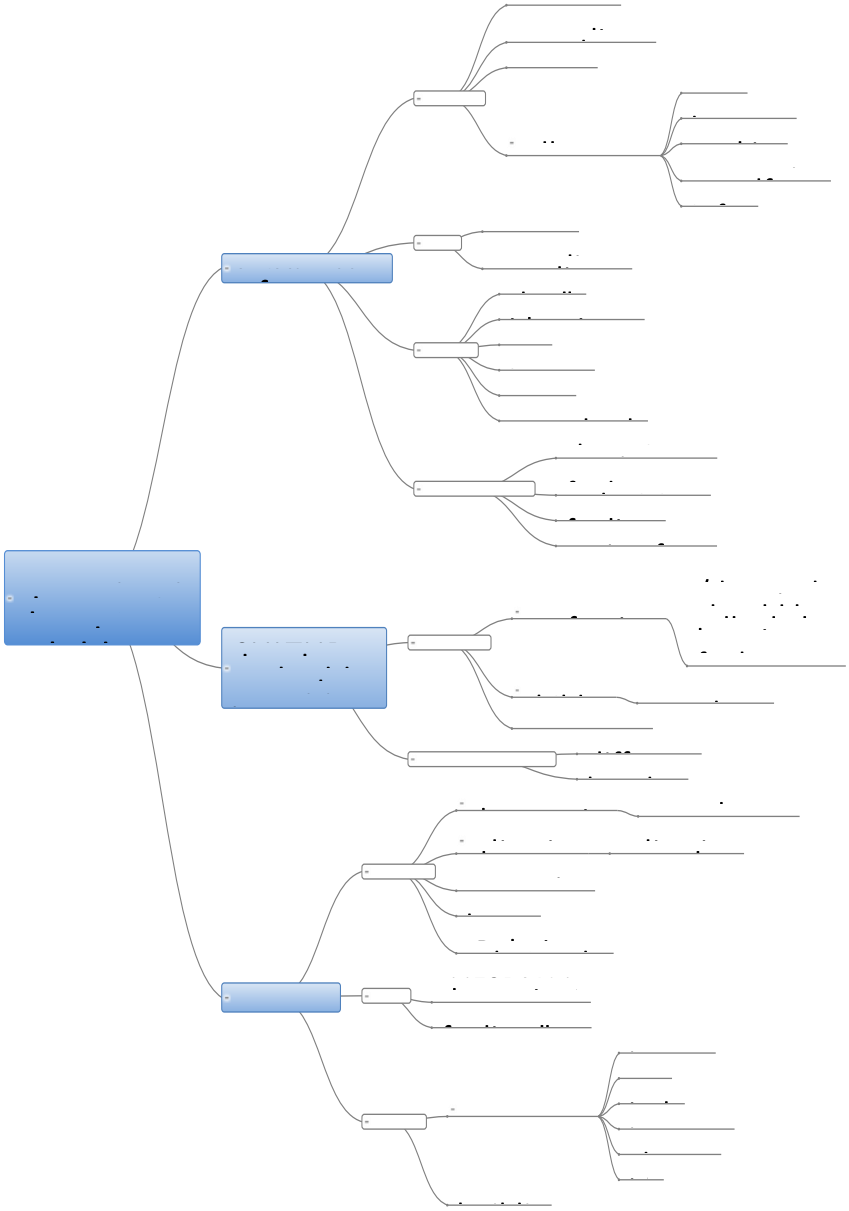
Wolverhampton

Appendix 11. Development of conceptual framework

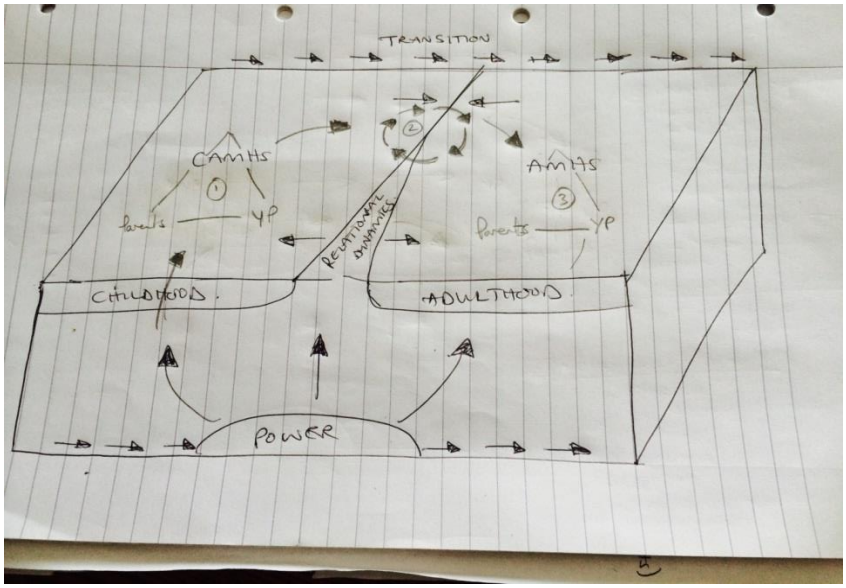
Appendix 11.1 Development of conceptual framework



Appendix 11.2 Power and transition



Appendix 11.3 Conceptual framework.



Appendix 11.4 Early Memos from July 2014

1. Pre- transition; The service user is deemed to be a minor and therefore deemed to not have the capacity to make decisions about treatment. This responsibility is with the service and the parents. However depending on the age of the service user professionals make decisions about the capacity of the service user using Fraser guidelines and Gillick competence.

In CAMHS there is an emphasis on systemic working, either in the form of family therapy, family work or formulating the service user's difficulties within the context of the family. Prior to the transition decision making involves all stakeholders. Power is shared between the service user, the parents and the service. Professionals work with the service user to empower and increase their autonomy.

2. Transition; at this stage the young person is either entering adulthood or is an adult and by law they are deemed to be responsible for their actions and decisions. AMHS and CAMHs work differently, and have different working practices as well as implementing ethical codes of conduct differently. This creates a tension between the two services. There are 'forces' that will either 'bridge the gap' or 'widen the gap'. It is the communicating styles which bridge the gap. So it is the level of negotiation (information sharing, communication, shared understanding of client need, use of language) adjustment (being flexible, adjusting working practices so that the service delivery in CAMHS is similar to service delivery in AMHS creating familiarity for the service user) and resolution (shared decision making, resolving differences of opinion) that facilitates the transition. What create the divide between the two services are the values and beliefs of the stakeholders (systemic vs individual, views about independence/ autonomy and social norms about adulthood) and also the organisational factors (e.g. procedures, ethical issues such as confidentiality, referral criteria, Governmental guidelines like the NICE guidelines and service structure). At this stage power begins to shift, from service to service and parent to child.

3. Post transition; power has now moved to AMHS and the service user. Parents are no longer legally able to make decisions on behalf of the service user (unless there is issue around mental capacity). The service user makes decisions about their treatment and AMHS are not obliged to discuss or involve in the decision making or treatment of service users. This can leave parents feeling 'alienated/ detached' or 'powerless' and the service user can experience feelings of loss, rejection, relief or fear following the transition.

Underpinning the transition process is the shift from child status to adult status and how this influences relational dynamics. For example, within the family system the young person is moving into adulthood, which according to some theorists means a change in role, identity, expectations, autonomy etc. This impacts on their relationships within the family, however for the young person with mental health difficulties, their transition into adulthood is somewhat 'catapulted forward' by the fact that they are in a mental health system.

Appendix 12. Rationale for the method

Although the literature review is generally conducted at the end of analysis so as not to contaminate the data, a preliminary search of the literature was required. The decision was made based on the need to ensure the study was an original piece that did not replicate extant research, a requirement of the Counselling Psychology doctorate programme. Also, it aided identification and clarification of the research questions; it was essential to explore existing research to determine whether gaps existed in the current knowledge about the topic under study.

The outcome of this preliminary search revealed this area was under-researched and little understood worldwide. This claim is supported by Singh et al., who as mentioned earlier conducted the only study of its kind and has contributed a significant amount of knowledge on transitional care. (Singh et al., 2008). On this basis, the aim of the current study was to explore and understand how service users, professionals and family members experience making the transition from CAMHs to AMHs. This immediately ruled out quantitative methods because these methods focus on testing or verifying existing variables and theory. As the research questions focussed on exploring the lived experience it meant starting from an exploratory position. Of the various qualitative methods, three main methods were selected and compared based on their ability to answer the research question (see Table 1, next page).

Having reviewed the differing qualitative methods, GT was viewed as the most likely to support the aims of the research, for the following reasons. According to Woolley, Butler and Wampler (2000) GT is an appropriate method to employ when little is known or understood about a phenomenon. This is particularly applicable to the current topic as GT itself is inherently exploratory and seeks to understand and articulate how people make sense of their experiences and interactions. The study aims to offer the researcher's interpretation of the experiences of a group of participants within the

specific context of making the transition from CAMHS to AMHS to elicit the process that occurs. Lastly, the aim of the research was to develop a theory which was able to describe and explain the transition process. The GT method seeks new theory (Denscombe, 1998) and aims at exploring and identifying social processes (Smith, 2008).

Table 68: Comparison of qualitative approaches considered

QUALITATIVE APPROACH	INVESTIGATES	AIMS TO	SUITABILITY TO THIS STUDY
Thematic analysis	Patterns in content and meaning	Identify and organise themes and relationships among themes	Partly suitable, as it would identify the important aspects of the transition process
IPA	Lived experiences of phenomena	Describe the quality of and texture of the individuals lived experience	Partly suitable, as it would provide an understanding of how stakeholders experience the transition
Grounded theory	Social processes	Describe and explain social processes	Has the potential to explain as well as describe the process of making the transition and provide a framework for devising interventions with clinical utility